Performance Report

Department of Health

1996

❖ *Executive Summary* ❖

1996 Performance Report

Mission and Vision

The mission of the Minnesota Department of Health is a broad one: to "protect, maintain and improve the health of our state's citizens." To accomplish that mission, MDH must function as a leader in safeguarding the health of the public, anticipating and meeting the health needs of all Minnesotans in a rapidly changing physical, social and technological environment. The priorities that guide MDH programs and activities are developed cooperatively. Program goals are achieved through ***partnerships*** with other agencies and organizations — in both the public and private sectors — and an ethic of ***shared leadership***, both inside MDH and with our external partners.

Core Functions

The public health system of Minnesota, under the leadership of MDH, serves three essential *core* functions.

Assessment consists of regularly and systematically collecting, assembling and analyzing information priorities on the health of populations, factors affecting people's health, and the health system itself.

Policy development involves leading communities in the development of public health priorities and collaborative strategies to improve population health, and assisting in the development of sound, comprehensive policies in matters related to health.

Assurance entails working both independently and with partners to assure that the appropriate activities to protect and improve public health are carried out. This has often involved the direct delivery of services to individuals not served by private health care providers.

Agency Goals

The overall program goals of MDH include:

- improving *health-related planning, decision making and research*, at all levels of government and in the private sector
- assuring efficient and effective *coordination of activities conducted by public health agencies* at the state and local level
- safeguarding and promoting the *health and safety of persons who receive services* from Minnesota health care providers
- *researching and developing policies* that support competition and other *cost-containment* initiatives
- ensuring that Minnesotans have *access to health care coverage*, and that they face *no financial, geographic or cultural barriers* to receiving quality health care
- reducing the occurrence of health problems that are *environmentally or occupationally induced*, or that are influenced by *lifestyle choices and cultural norms*
- *reducing the occurrence and severity* of acute and chronic disease
- preventing and controlling the *transmission of communicable disease*

November 1996
Executive Office
Minnesota Department of Health

Major Program Areas

Health Systems and Special Populations

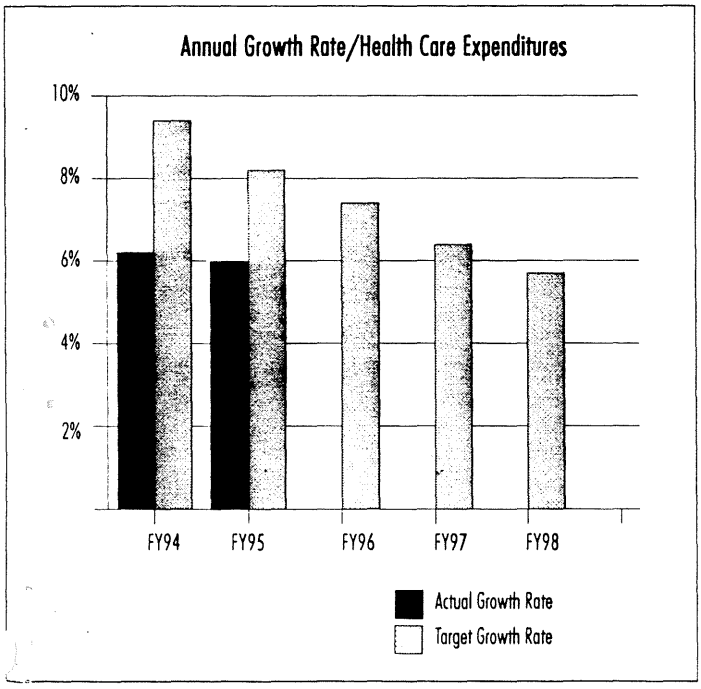
MDH is working to develop more effective public health partnerships with other agencies at all levels of government, as well as groups and organizations in the private sector, and to increase the capacity of local public health agencies to provide core public health services.

We are taking steps to improve the availability of health care services in underserved areas of the state. We are conducting education and technical support activities, and administering supplemental nutrition programs, in an effort to improve the health of mothers and children in Minnesota.

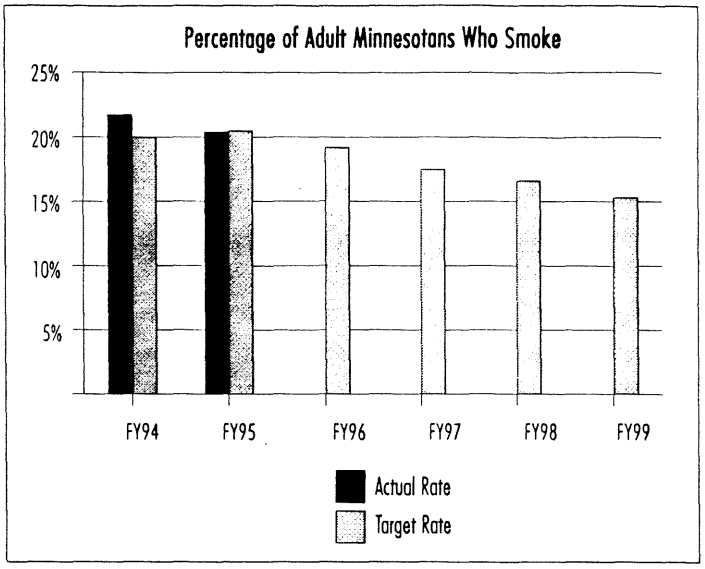
We provide information and education services designed to help people adopt healthier behaviors and make better lifestyle choices: We are working to contain health care costs, and help ensure the availability of health care coverage and high quality health care services in our state.

Examples of major current objectives:

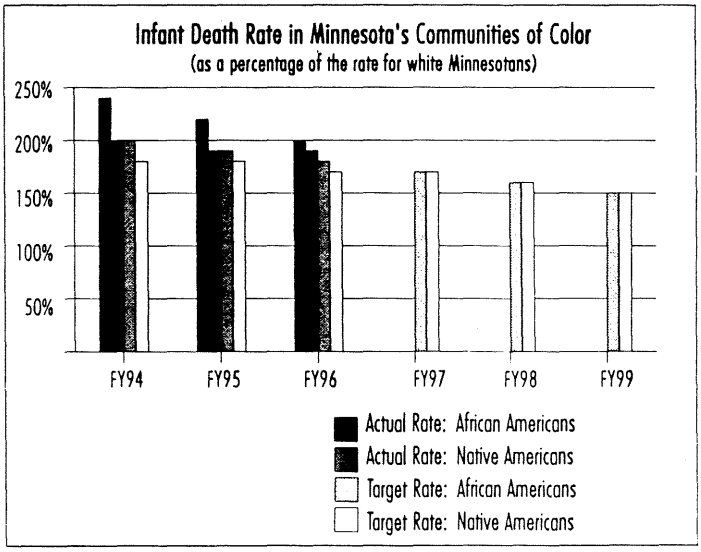
- *research* and develop state policies to *reduce the rate of growth of health care spending*



- *decrease* the *adult smoking rate* in Minnesota — from 20% in 1995 to 15% in the year 2000



- *decrease* the *disparity in the infant death rate* between white Minnesotans and the state's communities of color — reducing the rate for African American Minnesotans from 220% of the rate for whites in 1995 to 150% of the rate for whites by the year 2000, and reducing the rate for Native Americans from 190% of the rate for whites in 1995 to 150% of the rate for whites by the year 2000



Health Protection

MDH is working to improve its ability to monitor and respond to both chronic and communicable disease problems, and to reduce disease rates for AIDS, sexually transmitted diseases, and tuberculosis.

We are making a special effort to address previously unrecognized or re-emerging infectious disease problems, including the growing problem of foodborne illness. We are recognized national leaders in those areas.

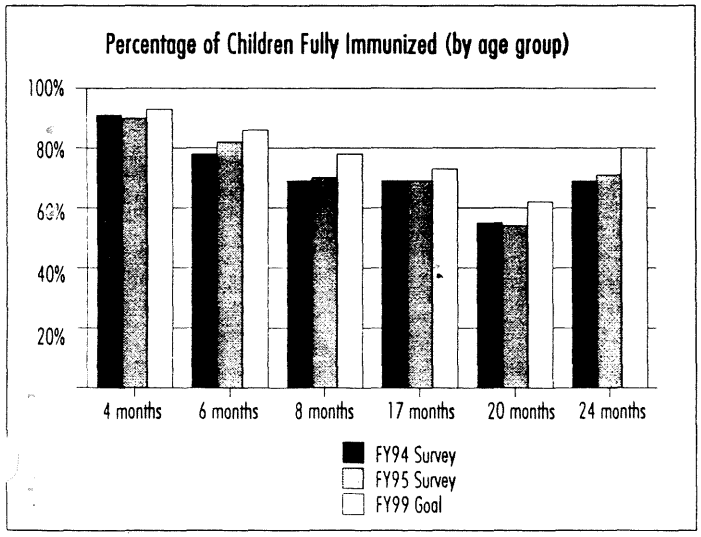
We are taking steps to improve screening rates for breast and cervical cancer among underinsured or medically underserved women, and to improve immunization rates for both adults and children.

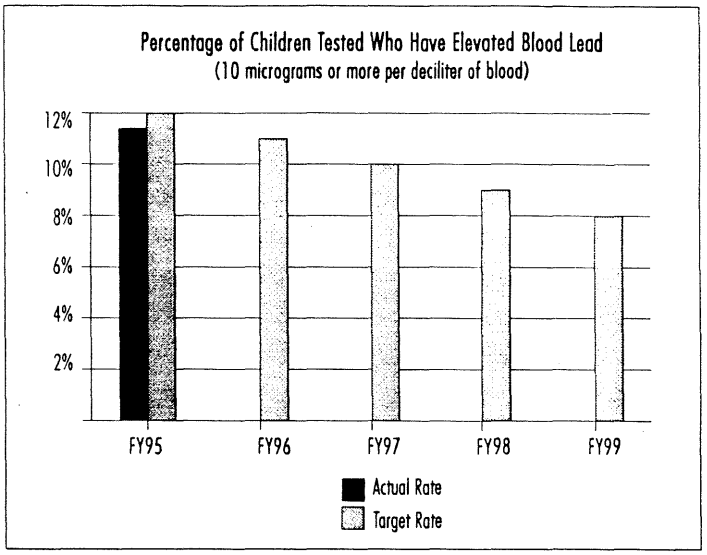
We are strengthening our programs to protect Minnesotans from potential health hazards in their food and drinking water, and to address possible human exposure to dangerous agents at hazardous waste sites or in the general environment. We are working to reduce exposure to potential health hazards in indoor air, and to prevent unsafe exposure to ionizing radiation from x-ray machines or nuclear power plants.

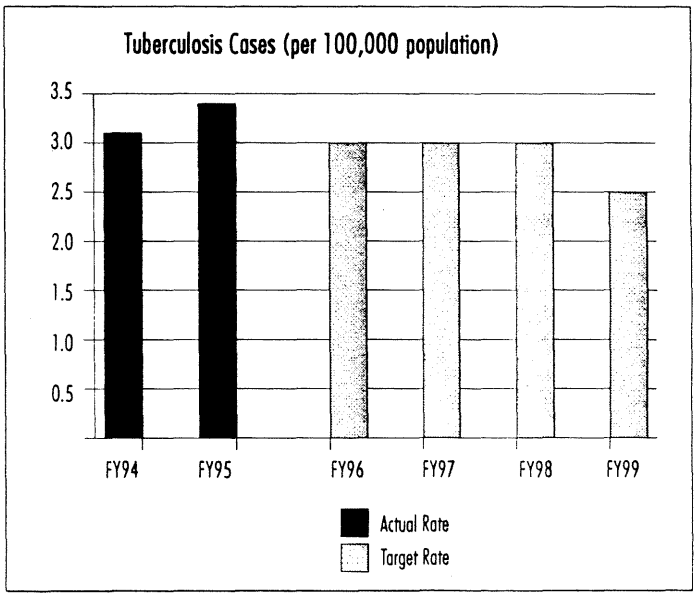
We are expanding and improving our capacity to provide state-of-the-art laboratory services, in support of both environmental and infectious disease control programs.

Examples of major current objectives:

- *increase* the percentage of *preschool children who are fully immunized* according to current public health recommendations, at each of the major "milepost" ages — four months, six months, eight months, 17 months, 20 months and two years
- *decrease* the percentage of children under six who, when tested for lead, are *found to have elevated blood lead levels* — from 11.4% in 1995 to 8% in 1999
- *decrease* the incidence of *tuberculosis* in Minnesota — from 3.4 cases per hundred thousand population in 1995 to fewer than two cases per hundred thousand population in the year 2000







AGENCY PERFORMANCE REPORT

1996

HEALTH DEPT

Final Format **Prepared : December 2, 1996**

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AGENCY : HEALTH DEPT

MISSION

The mission of the Department of Health (MDH) is to protect, maintain, and improve the health of the citizens of Minnesota.

VISION:
The department will be a leader on behalf of the public's health, with the capacity to anticipate and meet the health needs of all Minnesotans in an ever-changing world. In this environment, our priorities will be developed collaboratively, will guide our program activities, and will be achieved through partnerships and shared leadership.

GOALS

- To prevent and control the transmission of communicable disease in Minnesota.

- To reduce the occurrence and severity of acute and chronic disease.

- To reduce the occurrence of disease and conditions that are environmentally induced, occupationally induced, and influenced by lifestyle choices and cultural norms.

- To ensure access to coverage for Minnesotans who are uninsured as well as ensuring financial, geographic and cultural access to quality health care for all Minnesotans.

- To safeguard and promote the health and safety of persons receiving care from health care providers.

- To assure efficient and effective coordination of health related activities and services among state and local public health agencies.

- To improve decision making and health related planning and research at all levels of government and in the private sector.

- To reduce the rate of increase in health care expenditures in Minnesota.

ORGANIZATION

The department is organized into seven health programs and two administrative programs. The health programs are: 1.) Community Health; 2.) Family Health; 3.) Health Policy and Systems Compliance; 4.) Facility and Provider Compliance; 5.) Environmental Health; 6.) Disease Prevention and Control; and 7.) Public Health Laboratories. The administrative programs are the Finance and Administration Division and the Management Support Division.

WAYS TO IMPROVE PROGRAM OUTCOMES

What is today's context for public health?

The public health community faces many challenges stemming from the fact that we are living and working in an era of uncertainty and constant change. Advances in scientific knowledge and technology aid our work at the same time that they create more work to do. New pathogens continue to be identified, while known pathogens reappear. New populations (e.g.tiny premature babies, new immigrants, accident survivors, very old people) bring new health issues. Demographics show us a population that is both aging and more disabled than in the past. Changing geographic and income distributions have implications for public health. In addition, we face increasing changes in activity at the federal level, coupled with changing public expectations about government services.

The organization of the delivery and financing of medical care and health services has been changing rapidly in this decade. Recently, there has been a great deal of work done in developing a vision of a coordinated health system which builds on the complementary strengths of the public and private sectors to improve the health of the population.

Great strides have been made toward achieving the objectives of containing costs, increasing access to health care services, and continually improving the quality of the health care delivery system. Substantial reductions have been made in the rate of growth in health care spending. In the area of access, while about 9% of Minnesotans are uninsured at any given time, we have one of the highest rates of insured people in this nation. More importantly, the rate of people who are insured in Minnesota has remained stable since 1990, while the rate of the number of people uninsured across the country has continued to rise. In the area of quality, the health care community faces its biggest challenge, and the public health community has the opportunity to continue to make significant contributions into the future by developing quality measures that are more predictive, preventive, and responive to consumers' needs than the today's more reactive measures.

Public-private partnerships in health care have now become a reality, and the challenges facing the Minnesota Department of Health center around issues of role definition and accountability. We are positioned to take significant steps toward the development of a coordinated health system which builds on the complementary strengths of the public and private sectors to improve the health of the population. Our challenge lies in sorting out who is responsible for what, how to hold each other accountable, and how to measure accountability.

What does this mean for program outcomes?
All these factors affect the extent to which the Department is able to achieve planned outcomes, and whether or not it is able to meet its goals. Constant change of the magnitude described above presents a considerable challenge in focusing resources, working with others toward a shared vision, evaluating program effectiveness, and building stable working partnerships. Uncertainty about financial resources is also a challenge to maintaining necessary program continuity, managing current resources, and planning for the future.

Advances in scientific knowledge and medical technology, evolving relationships with our partners, success of earlier public health efforts, experience gained from program evaluation, and advances in information technology can all contribute toward an improved ability to achieve our objectives, reach our goals, and fulfill our mission.

How can MDH address these issues?
Many of the factors noted above as affecting MDH's ability to achieve stated outcomes are beyond the scope of the department's influence. Nevertheless, through a strategic planning process, the department has identified several ways to proactively and pragmatically approach these issues and contribute to improved outcome. These methods include the following:

* Guiding Principles:
Over the past year, the MDH has initiated a department-wide process intended to create a framework to guide its work in this new environment. Through this process, it has developed the following five guiding principles:

1. Setting priorities and focusing resources
As the state's lead public health agency, we provide leadership in setting statewide priorities to improve the health of Minnesotans, and we focus resources to solve those problems that we are uniquely qualified to address.

2. Commitment to protecting and promoting the public's health
We are committed to protecting the public's health and preventing disease, premature death, and injury, and to promoting health and quality of life through a variety of approaches, including education, incentives, and regulatory activity.

3. Partnerships
Viable and effective partnerships are essential to accomplishing our mission. We encourage collaboration and strong relationships with all of our internal and external partners, believing that we are successful when others succeed.

4. A work force that ensures success
MDH recognizes that its employees are its most important resource. We are committed to promoting diversity, strengthening staff competence by promoting training, education and support; and building the capacity of all employees to work together in a shared leadership environment. Essential to accomplishing our mission is a work environment that ensures that all employees are prepared to meet the challenges of the future.

5. Importance of stewardship of public resources
We practice sound stewardship in the use of public resources to protect and promote the health of the public. We recognize there are competing priorities for the allocation of public resources, and we acknowledge and support the agency's obligation to act as a responsible steward of the public's trust.

* Public Health Goals
In 1995 MDH published the Minnesota Public Health Goals. The 18 goals named in this report reflect the public health needs that have been identified by people in communities throughout Minnesota, and they often correspond to the performance measures outlined in this report. The public health goals include measures such as promoting healthy families through improved services to parents, children and adolescents, including those with special needs; protecting the health of the citizens of Minnesota by identifying and mitigating environmental health risks; and preventing and/or controlling infections diseases. The public health goals are intended to provide a common direction for the many entities that are working to improve the public's health, including public health agencies, medical care providers, Regional Coordinating Boards (RCB's), health plan

companies, and voluntary organizations. These goals have stimulated and encouraged voluntary efforts toward the development of healthy communities. The department is working on a planning process, in conjunction with the community, to develop priority goals for 1998. By working closely with the community to achieve a set of common goals, the MDH should be able to improve the corresponding performance measures.

* Core Functions
The tools that MDH uses to accomplish its goals are the three "core functions"of public health:

Assessment consists of regularly and systematically collecting, assembling, and analyzing information priorities on the health of populations, factors affecting people's health, and the health system itself.

Policy Development involves leading communities in the development of public health priorities and collaborative strategies to improve population health, and assisting in the development of sound, comprehensive policies in matters related to health.

Assurance entails working both independently and with partners to assure that the appropriate activities to protect and improve public health are carried out. This has often involved the direct delivery of services to individuals not served by the private health care providers.

* Information Technology Infrastructure
The extent to which MDH is able to achieve its public health mission depends largely on the availability of accurate, comparable, timely, complete, and accessible information. MDH has developed a proposal to implement a plan for improved information resources management infrastructure within the department. This will establish a coordinated information system for the collection, analysis, and dissemination of information, in support of population health goals. The department will establish an ongoing plan, process, and organizational structure to align the use of data and technology with the department's mission.

Thus, by using our guiding principles, by focusing on our public health goals, by utilizing the core function tools, and by improving our information management resources, MDH plans to continue to meet our objectives and improve our program outcomes.

EMPLOYEE PARTICIPATION

The employee input into the Performance Indicators Report was developed primarily through the Worker Participation Committee. The committee was comprised of a cross-section of staff throughout the agency, (see list below) as required in Minnesota Statutes, 15.92.

The report was distributed to the members of the committee in draft form for their review prior to the meeting to discuss the report in aggregate. When the committee met, they reviewed the document. Each member provided suggestions and recommendations as to how the report could be improved. Committee members who could not attend the meeting shared their suggestions in writing.

These recommendations were shared with the agency management and the Executive Office. Changes were incorporated based on this input. The final document was based on agency management and Executive Office input to the draft put together by the Worker Participation Committee.

Membership of Worker Participation Committee:

* David Giese (Chair)
* Mark Bergquist (Commissioner's Plan)
* Kim Jeppesen (MAPE)
* Mary Manning (Managerial Plan)
* John Oswald (Management Representative)
* Mel Sailor (AFSCME)
* Jerry Smith (MN Government Engineer's Council)
* Janice Jones (Human Resources Management)
* Bob Gunkle (Middle Management Association)
* Open Position (Management Representative)

Date : December 2, 1996

Agency Expenditure Summary

F.Y. 1996

NAME	(in thousands $)	% of $	FTE	% of FTE
AGENCY: HEALTH DEPT	$186,354	100.0%	1,092	100.0%
BACT: FACILITY/PROVIDER COMPLIANCE	$15,356	8.2%	195	17.8%
BACT: COMMUNITY HEALTH SERVICES	$21,681	11.6%	91	8.3%
BACT: FAMILY HEALTH	$86,435	46.4%	149	13.7%
BACT: HLTH POLICY & SYST COMPLIANCE	$9,603	5.2%	81	7.4%
BACT: PUBLIC HEALTH LABORATORIES	$5,388	2.9%	86	7.9%
BACT: ENVIRONMENTAL HEALTH	$16,121	8.7%	205	18.7%
BACT: DISEASE PREVENTION & CONTROL	$19,825	10.6%	163	14.9%

Agency : HEALTH DEPT

Program : HLTH SYST & SPEC POPULATIONS

BACT : FACILITY/PROVIDER COMPLIANCE

EXPENDITURES AND STAFFING :

	($ in Thousands)	Percent of Department
Total Expenditure	$15,356	8.24%
From Federal Funds	$988	
From Special Revenue Funds	$12,163	
General	$2,205	
Number of FTE Staff:	195	17.84%

GOALS :

- To assure the quality and quantity of care provided for nursing home residents and persons living in certified Intermediate Care Facilities for the Mentally Retarded and Institutions for Mental Diseases (Regional Treatment Centers) is based on care needed and received. (M.S. 144.072, P.L. 92-603, 42 CFR 456)

- To assure a comfortable, sanitary and safe environment for patients and residents of health care facilities by ensuring compliance with state and federal physical plant requirements for health care facilities. (M.S. 144.50-56 & 144A.01-07, Titles XVIII (Medicare) & XIX (Medicaid) of the Social Security Act)

- To protect the public health and safety of patients and residents receiving services in licensed/certified health care providers by ensuring they conduct their activities in compliance with state and federal regulations. (M.S. 144.50-56 & 144A.01-07, Titles XVIII (Medicare) & XIX (Medicaid) of the Social Security Act)

- To ensure health and safety of consumers in health care settings, investigate complaints, perform background study checks and to take necessary actions to assure that those responsible for instances of abuse and neglect are no longer eligible to work in a health care facility. (M.S. 626.557)

DESCRIPTION OF SERVICES :

The mission of the Facility and Provider Compliance Division is to safeguard and promote the health and safety of the individuals receiving services from health care providers in regulated settings, and to assure health care expenditures reflect the services needed and provided. This division is regulatory in nature and is comprised of 5 sections: Licensing and Certification, Engineering Services, Case Mix Review, Office of Health Facility Complaints, and Management Services.

Case Mix Review (formerly Quality Assurance & Review) conducts annual reviews of all medicaid recipients and private pay residents in certified nursing facilities and intermediate care facilities for the mentally retarded. This activity is accomplished through onsite reviews, whose purpose is to assure the quantity and quality of services are appropriate to the individual needs of the residents. The program ensures that the daily rates charged by nursing facilities for residents care is based on the actual care needed and received by each resident.

Engineering Services ensures that all new construction or remodeling of health care facilities complies with federal and state law. This is accomplished through the review of all construction plans and the inspection of completed projects. By providing consultation and requiring approval of building plans, the section ensures that facilities' expansion, replacement, or remodeling projects comply with applicable law. This benefits consumers and providers by assuring facilities' physical plants meet basic safety and health requirements, as well as by avoiding costly mistakes requiring correction after building projects are completed.

Licensing and Certification (formerly Survey and Compliance) provides assurance of quality care to recipients of health care services. This is accomplished by inspections and monitoring of health care providers. This program is also responsible for managing the federally mandated Nursing Assistant Registry which maintain eligibility information on 45,000 certified nurse aids in Minnesota, as well as review 125 training programs for nurse aides.

Office of Health Facility Complaints investigates complaints lodged against health care providers. Special investigators,conduct investigations and take regulatory action when violations are found. They also investigate complaints of abuse and neglect by nursing assistants, and report any substantiated complaints to the Nursing Assistant and/or to the Minnesota Department of Human Services, Background Study Unit, for possible disqualification for employment in a health care facility.

Management Services coordinates the activities of the Division. Services include program and fiscal planning, information system management, promulgation of administrative rules, coordination of administrative appeals, and functions as liaison with other state agencies, the U.S. Department of Health and Human Services, consumer advocacy groups and providers.

BACKGROUND INFORMATION :

MEASURE TYPES: ACTIVITIES (A), EFFICIENCY (E), OUTPUT (O), OUTCOMES (OC), OTHER DATA (OD), UNIT COSTS (UC), WORKLOAD (W)

DATA BASED ON: CALENDAR YEAR (CY), FISCAL YEAR (FY), FEDERAL FISCAL YEAR (FFY), BIENNIUM YEARS (BY)

Type	Based	Measure	1994-95	1995-96
W	FY	Audits	10,362	10,472
W	FY	Reconsiderations	1,940	1,747
OD	FY	Savings (from Audits and Reconsiderations)	$6,024,861	$6,764,400
W	FY	Inspection of Care Recommendations	$4,045	$2,891
W	FY	Construction Plans Reviewed	172	170

W	FY	Construction Inspections	256	190
W	FY	Licensing/Certification Surveys	1,834	1,635
OD	FY	Number of Violations	8,336	5,509
OD	FY	Number of Violations per Survey	6.12	4.34
W	FY	Nursing Assistant abuse or neglect reported to Registry *excluding reports from other states	55	44
W	FY	Total Vulnerable Adult Act complaints received	596	592

PROGRAM DRIVERS :

Aging Population. The number and percentage of Minnesotans aged 65 and older is increasing, as is the level of medical care they require. This creates a greater demand for continued assessment of the needs of the individuals in long term care settings to assure they are appropriately placed, receiving services to meet their needs, and their payment rate reflects the level os services needed and received.

Increases in Medical and Health Care Costs. Increases in medical and health care costs have resulted in the creation of alternatives to traditional health care delivery services, such as outpatient surgical centers and community based residential long term care settings. As society looks for cost effective ways to deliver health care services, it is important that the quality of those services is maintained.

Increased Emphasis on Enforcement. The increased federal emphasis on enforcement in long term care settings has resulted in a survey/investigative process demanding more detailed documentation capable of sustaining legal challenge.

Changing Federal and State Requirements. The division is responsible for ensuring compliance with both federal and state requirements in regulated health care settings; therefore, as regulations change, there is a continuing need for training provider and division staff. In addition, the division must continually re-examine state regulations as federal regulations change to eliminate conflicting requirements, while maintaining Minnesota's standards for quality of care and services.

Goal 1 : To assure the quality and quantity of care provided for nursing home residents and persons living in certified Intermediate Care Facilities for the Mentally Retarded and Institutions for Mental Diseases (Regional Treatment Centers) is based on care needed and received.

Objective 1 : To assess 100% of residents, and audit a minimum of 10% of facility-performed assessments, to assure the quality, quantity and payment of services provided to residents in certified long term care facilities reflects care needed and provided to the individual residents. (M.S. 144.072 - 144.0723, 256B.431)

Measure 1 : Savings in long term care expenditures due to corrected classifications through audits and reclassifications.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
# Assessments by NH						
Actual	103,136	102,360	103,260			
Target	102,000	104,000	105,000	105,000	105,000	105,000
# Audits by CMR staff						
Actual	10,360	10,362	10,472			
Target	10,200	10,400	10,500	10,500	10,500	10,500
Savings						
Actual	$4.6M	$5.1M	$5.3M	$5.3Me	$5.3Me	$5.3Me
# Reconsiderations						
Actual	1,971	1,940	1,747			
Target	2,100	2,000	1,900	1,800	1,900	1,900
Savings						
Actual	$1.3M	$1M	$1.5M	$1.5Me	$1.5Me	
Target						$1.6M
Total Savings						
Actual	$6.0M	$6.0M	$6.8M	$6.8Me	$7.1Me	$7.1Me

DEFINITION :

Under current case mix rule, resident care needs and the costs of maintaining those needs are assessed on admission, annually by Case Mix Review Teams, semi-annually by the facility, after hospitalizations, 30 days post-hospitalizations, and when residents are transferred between different levels of care or facilities. A case mix classification is a rating used to determine cost of care. Approximately 145,000 case mix assessments are processed annually.

Case Mix Review Program personnel annually review the assessment levels, and conduct a twice-yearly onsite audit of a minimum of 10% of the assessments performed by nursing home staff to assure the payment levels reflect the care needed and received by each resident. Up to 100% audits are performed in a facility if a error percentage of 35% or greater is found. Fifteen facilities were the subject of 100% audits in SFY 1995. Onsite audits have resulted in significant savings in dollars paid by individuals and by Medical Assistance. In addition, a reconsideration (requested by or on behalf of the resident or a facility) of the assigned case mix classification often results in additional savings for individuals and the Medical Assistance program.

RATIONALE :

State law requires the case mix classification program to allow for audits and reconsiderations (M.S. 144.0722).

DATA SOURCE :

MDH Case Mix Review (CMR) data from CMR staff assessments and audits and from facility generated assessments, available at the CMR offices, 393 North Dunlap Street, St. Paul.

DISCUSSION OF PAST PERFORMANCE :

Minnesota has used a case mix reimbursement system since 1985 to control increasing Medical Assistance costs, by determining that nursing home payment rates are based on resident care needs. Minnesota has an "equalization" law requiring that rates for private paying residents are no higher than rates charged to Medical Assistance recipients. All residents of nursing homes that participate in the Medical Assistance program receive a case mix classification.

PLAN TO ACHIEVE TARGETS :

Case Mix Review Program personnel annually review the assessment levels, and conduct a twice-yearly onsite audit of a minimum of 10% of the assessments performed by nursing home staff to assure the payment levels reflect the care needed and received by each resident. Up to 100% audits are performed in a facility if a error percentage of 35% or greater is found. In addition, a reconsideration (requested by or on behalf of the resident or a facility) of the assigned case mix classification often results in additional savings for individuals and the Medical Assistance program.

OTHER FACTORS AFFECTING PERFORMANCE :

There is the continuing struggle to balance the demands of nursing home providers for adequate compensation to ensure quality of care with the public's demand for health care costs. The number and percentage of Minnesota's population age 75 or older is increasing, as is the acuity level of nursing home residents. This creates the need for a continuation of individualized assessments to assure appropriate placement and care which results in a correct level of payment.

The population in the intermediate care facilities for the mentally retarded continues to diminish as waivered services are developed for the clients. This is resulting in fewer mandated reviews for the case mix program. A major concern is that lack of oversight in these waivered facilities may result in diminished quality and quantity of care for a vulnerable population.

The long term care system in Minnesota is currently being evaluated as to the most effective and cost efficient way to provide quality health care services to the population needing those services. The Department must continue to operate the existing case mix system, while at the same time prepare for anticipated changes to how long term care services are delivered and paid for in the future.

Goal 1 : To assure the quality and quantity of care provided for nursing home residents and persons living in certified Intermediate Care Facilities for the Mentally Retarded and Institutions for Mental Diseases (Regional Treatment Centers) is based on care needed and received.

Objective 1 : To assess 100% of residents, and audit a minimum of 10% of facility-performed assessments, to assure the quality, quantity and payment of services provided to residents in certified long term care facilities reflects care needed and provided to the individual residents. (M.S. 144.072 - 144.0723, 256B.431)

Measure 2 : Number of recommendations made by CMR staff to the nursing facility for medical or nursing care plan revisions regarding the residents' care.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Recs made in NHs:						
Medical						
Actual	952	728	463	500e	525e	525e
Nursing						
Actual	1002	1208	925	950e	975e	975e
Speech/Hear/Vision						
Actual	10	10	3	10e	12e	12e
Dental						
Actual	18	18	0	10e	12e	12e
Psych Svcs						
Actual	1	1	1	1e	1e	1e
Social Svcs						
Actual	480	241	205	225e	230e	230e
Activities						
Actual	188	183	101	125e	130e	130
Dietary						
Actual	64	79	40	45e	50e	50
Rehab (PT, OT)						
Actual	42	48	21	25e	30e	30
Program of Care						
Actual	323	357	216	225e	230e	230e
Antipsych Med Moni						
Actual	108	70	49	50e	55e	55
Recs in ICFs/MR:						
Case Manager						
Actual	844	746	602	550e	545e	545e
ISP/IPP						
Actual	147	144	97	90e	80e	80
Medical						
Actual	45	32	22	15e	12e	12e
Nursing						
Actual	70	65	54	45e	40e	40e

Communication						
Actual	1	2	0	1e	1e	1e
Dental						
Actual	3	4	1	1e	1e	1e
Psych Svcs						
Actual	1	0	1	1e	1e	1e
Direct Care Staff						
Actual	94	100	84	75e	70e	70e
Dietary						
Actual	7	7	6	5e	5e	5e
Rehab (PT, OT)						
Actual	3	2	0	1e	1e	1e
Activities						
Actual	0	0	0	1e	1e	1e
Total IOC Recs						
Actual	4,403	4,045	2,891			
Target	4,600	4,650	4,650	2,951	3,007	3007

DEFINITION :

Certified long term care facilities, whether a nursing facility (NF) or intermediate care facility for the mentally retarded (ICF/MR), are eligible to receive funding from the federal Medicare or Medical Assistance programs. Through the federal Inspection of Care (IOC) activities, the Case Mix Review Program reviews clinical records and observes/interviews all residents in certified NFs and ICFs/MR to assess the appropriateness of the individual's placement and plan of care. Any problem identified in those reviews and interviews is shared with the facility in the form of a "recommendation" for an alternative placement or for the need to review the resident's plan of care for possible revisions. These IOC activities are conducted along with the annual case mix reviews by the Case Mix Review Program. The implementation of a recommendation can have a direct impact on the health, safety, comfort, treatment, or well-being of a resident.

RATIONALE :

State law requires MDH to conduct assessments of the appropriateness of the cares provided to nursing facility (NF) and intermediate care facility for the mentally retarded (ICF/MR) residents (M.S. 144.072 - 144.0721).

DATA SOURCE :

MDH Case Mix Review data from CMR staff assessments and audits and from facility generated assessments, available at the CMR offices, 393 North Dunlap Street, St. Paul.

DISCUSSION OF PAST PERFORMANCE :

The annual assessment by the Case Mix Review Team also includes individualized recommendations for revisions in the plan of care of residents. Over 4,000 individualized recommendations were written in 1996. These recommendations provide a method for the Case Mix Review Program to address areas of the resident's care where changes to the plan of care might better address the resident's needs or preferences. The Division's Medical Advisor works closely with Program personnel in addressing medical standards of care. Recommendations for persons in ICFs/MR are sent to the facility and to the Department of Human Services. Responses to all recommendations are reviewed by Program supervisors and the program manager. These recommendations provide a direct link between the Case Mix Review Program and the quality of care and quality of life of the resident. The following lists illustrate the variety of recommendations written by CMR Program Teams. This tracking provides data for the Program to use for developing and providing provider training.

PLAN TO ACHIEVE TARGETS :

The annual assessment by the Case Mix Review Team provides an opportunity for the Program to provide educational information to the facility. Trend analysis is an ongoing process in the Program. Data is collected and used for studies and identification of long term care issues such as restraint use, psychotropic drug usage, acuity of residents, activities of daily living (ADLs), and other factors regarding the changing long term care environment.

OTHER FACTORS AFFECTING PERFORMANCE :

Same as measure 1.

Goal 2 : To assure a comfortable, sanitary and safe environment for patients and residents of health care facilities by ensuring compliance with state and federal physical plant requirements for health care facilities.

Objective 1 : To review 90% of all construction plans submitted within 60 days of receipt so that construction projects can proceed in a timely manner.

Measure 1 : Percent of construction plans reviewed within 60 days of receipt.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance % of plans reviewed in less than 60 days						
Actual	80 of 167%	97 of 172%	95 of 170%	90e%	90e%	90%
Target	80%	90%	90%	90%	90%	90%

DEFINITION :

The program must review and approve final plans for all construction or remodeling projects associated with licensed health care facilities (hospitals, nursing homes, hospices, boarding care homes, supervised living facilities, and outpatient surgical centers). Architects must submit plans for review, revision, and approval to assure compliance with state and federal codes for construction and fire safety.

In addition, prior to a nursing home receiving certification to receive payments through the Medicare or Medicaid programs (as well as to maintain its certification), it must be inspected annually for compliance with the Life Safety Code. This inspection is completed by the State Fire Marshal's office under contract with the Department of Health. This fire safety inspection is completed at the same time the health survey is conducted by the Department's health surveyors from Licensing and Certification.

Approximately 191 of the Intermediate Care Facilities for Mentally Retarded (ICFsMR) in Minnesota are built to fire safety standards which would allow residents and staff to "defend in place" in the event of fire. This means residents and staff would be able to avail themselves of fire safety features, such as automatic sprinkling. However, there are 127 of these facilities that do not have this level of fire safety features. In these facilities, an "evacuation difficulty evaluation" (E-score) must be completed annually for each resident to determine the number of staff required so that residents can be quickly evacuated in case of fire or other emergency.

RATIONALE :

The 60 day turnaround time is an internal quality measure implemented to ensure that building projects are not unnecessarily delayed by the initial plan review. Compliance with construction requirements is achieved by performing a combination of activities such as plan reviews, inspecting new construction and remodeling projects, providing technical assistance to architects, and by ensuring that state and federal regulations are maintained. One of the key components of maintaining the regulations, is to constantly be aware of opportunities to resolve remodeling project issues through the "waiver process" when the cost of implementing the improvement would not add value or increase the safety of residents.

Federal law requires that all health care facilities receiving payment under the Medicare or Medicaid programs be inspected for compliance with the National Fire Protection Association's Life Safety Code. (42 Code of Federal Regulations, sections 483.70 and 483.470).

DATA SOURCE :

The date that construction plans are received and the date the review is completed are among the data available in the engineering plan tracking system. The fire safety inspections and "evacuation difficulty evaluation" data is maintained by the Licensing and Certification Section.

DISCUSSION OF PAST PERFORMANCE :

Since fiscal year 1994, the program has met or exceeded the turnaround time goal. This is due to the addition of one engineer position midway through fiscal year 1993, and due to improved automation. The engineering plan tracking system was developed in 1992 to enable the engineering staff to monitor the status of construction projects from the date of the original receipt of the plan to the completion of the building project.

PLAN TO ACHIEVE TARGETS :

An engineer position was eliminated during FY'96 due to federal funding cuts. This represents a 20% decrease in engineering staff. However, with the increased automation developed over the last few years, the goal of reviewing 90% of construction plans within 60 days of receipt will be a challenge given the decrease in staff. The program is monitored for additional potential uses of automation and refinement of the project tracking system. The program is involved in the development and promulgation of revisions to the licensing rules for physical plant in licensed health care facilities and updates its tasks as needed to comply with those revisions.

OTHER FACTORS AFFECTING PERFORMANCE :

The number of construction plans submitted for review varies; more are submitted following statutory or rule changes in reimbursement formulas to health care facilities and following the nursing home moratorium exceptions process.

Goal 3 : To protect the public health and safety of patients and residents receiving services in licensed/certified health care providers by ensuring they conduct their activities in compliance with state and federal regulations.

Objective 1 : By the year 2000, nursing homes cited for resident assessment deficiencies will decrease by 20%.

Measure 1 : The annual percentage change of nursing homes with deficiencies in resident assessment.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
No. of surveys						
Actual	373	431	413	420e	420e	420e
No. deficiencies						
Actual	165	235	102	95e	87e	80e

DEFINITION :

The Licensing and Certification Program (L&C) assures state and national standards are maintained in quality of life, quality of care, facility safety, fire prevention, emergency evacuation, dietary, staffing, infection control, and other critical health care components, through regular unannounced inspections of health care providers. The health care providers under L&C regulatory authority include: hospitals, nursing homes, intermediate care facilities for the mentally retarded, home health agencies, hospices, end-stage renal dialysis suppliers, clinical laboratories, and others.

Specially trained teams of registered nurses, sanitarians, dietitians, fire safety and other inspectors go on-site and evaluate the ability of the provider to deliver safe, high quality care to Minnesota consumers. If unacceptable conditions are found, statements of deficiencies (federal) and/or correction orders (state) are issued. For each deficiency or correction order issued, there is an opportunity to correct the problem within time frames which are determined based on the affect of the problem on consumer health and safety. Failure or inability to correct can result in loss of Medicare/Medicaid funding, fines, forced changes in ownership/management, or even closure and loss of license to operate in Minnesota. Broad authority and specialized staff resources allow L&C to have a direct impact on the quality of life and on health care delivery in Minnesota.

In addition, L&C manages the federally mandated Nursing Assistant Registry. Eligibility information on 47,000 certified nursing assistants in Minnesota is maintained on the Registry. Staff also reviews 125 training programs for nursing assistants.

One of the most important pieces of both the federal and state regulations is the resident assessment, which provides information on the resident's condition, strengths and weaknesses, needs and preferences. The resident assessment is used to develop the resident's plan of care. The plan of care is the basis for determining the type an quantity of services to be provided to the resident.

FY'93 and FY'94 were years in which the reporting system was changed by the federal government. Prior to FY'93, deficiencies were issued under a number of single - but related - violations. The change incorporated several of these related violations and grouped them, thereby reducing the number of single-related deficiency violations. In FY'96, the federal Enforcement Process was implemented which resulted in further tightening of federal violations.

RATIONALE :

An accurate and complete resident assessment will provide the basis for the resident to receive the appropriate cares and services to meet that resident's needs and choices (care plan). An inaccurate or incomplete resident assessment can have a direct negative impact on the health and safety of that resident.

DATA SOURCE :

The source of the data are the OSCARS reports. OSCARS is a federal data base which is supported by state entry of status information. The data are collected annually and can be obtained at the MDH Facility and Provider Compliance Division, 393 N. Dunlap St. (Central Medical Building), St. Paul. For purposes of this measure, Tag F0272 is being tracked.

DISCUSSION OF PAST PERFORMANCE :

"Regulatory reform" became an important concept beginning in the early 1990's and continues to provide the framework in which laws and rules are written. The idea is to retain regulations that have meaningful measures and outcomes and eliminate duplicative and non-essential regulations. As a part of regulatory reform, there have been state and national trends toward developing "outcome based" regulation and evaluation. Outcome based regulation purports to establish minimum requirements which, if observed, will produce desirable outcomes. The F&PC Division has selected the area of "resident assessment" as a key indicator of an outcome based regulation. The number of violations in this area is being tracked over time, with the goal of reducing violations.

PLAN TO ACHIEVE TARGETS :

As the federal government continues its movement toward outcome-based performance measurement, state agencies are being expected to adhere to federally mandated inspection protocols. The rationale is that the federal government will only be able to make meaningful outcome evaluations and comparisons if all state agencies maintain the discipline to perform their activities as mandated. With this in mind L&C will continue to follow inspection protocols as determined by the federal government, however, the Division will target a portion of its education and training efforts of staff and providers to addressing the importance of developing an accurate resident assessment. The Division is utilizing its clinical nurse specialists and medical director positions to develop training and education materials, and is partnering with industry trade associations to provide technical assistance about the benefits and importance of conducting thorough and well developed resident assessments, and how to improve compliance in this area.

OTHER FACTORS AFFECTING PERFORMANCE :

The federal government determines its priorities with respect to protecting the health, safety and welfare of persons receiving services for which it funds or reimburses. A significant amount of funding for F&PC activities is provided by the federal government. As such, the parameters of F&PC's activities are negotiated with and determined by the federal government. F&PC must select objectives and measures which work within the federal parameters. The Division will be successful in selection and implementation of these objectives and measures as long as the federal government is willing to fund, as part of staff position descriptions, activities of technical assistance and education, instead of limiting funding to enforcement activities only.

Goal 3 : To protect the public health and safety of patients and residents receiving services in licensed/certified health care providers by ensuring they conduct their activities in compliance with state and federal regulations.

Objective 2 : By the year 2000, reduce the use of physical restraints in nursing homes by 50%.

Measure 1 : The annual percentage of nursing home residents in physical restraints.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percentage of residents in Restraints						
Actual	55.6%	42.0%	32.2%	28.0e%	22.0e%	16.0e%

DEFINITION :

Physical restraints are defined as "any manual method or physical or mechanical device, material or equipment attached to, or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body."

RATIONALE :

Physical restraints may cause many problems, including: falls, strangulation, loss of muscle mass and tone, pressure sores, decreased mobility, agitation, reduced bone mass, stiffness, frustration, loss of dignity, incontinence, constipation from limited mobility; aspiration pneumonia, skin abrasions and breakdown; contractures; bone demineralization; and decreased ability to ambulate independently. According to OSCAR data, Minnesota nursing homes utilize physical restraints at a rate higher than reported national average, and well above the clinically recommended rate of 5%. Minnesota restraint use rate is reported at 23% and the national restraint use rate is reported at 19%. The benefits of reducing restraint use include less agitated residents, improved quality of life and functional status of resident, less use of antipsychotic drugs, less skin breakdown, more continent, less falls, less confusion.

DATA SOURCE :

The source of the data is Case Mix Review Program data. Case Mix Review data involves looking for documentation in each resident's record of restraint use. The data can be obtained at the MDH Facility and Provider Compliance Division, 393 N. Dunlap St. (Central Medical Building), St. Paul, MN 55164-0900.

DISCUSSION OF PAST PERFORMANCE :

Minnesota utilization rates for physical restraint use are higher than the reported national average. F&PC has worked with the nursing home industry ombudsman to educate providers and consumers on the undesirable effects of restraint use and the need to reduce utilization. Local media has been interested in this issue, and has done feature articles in an effort to educate the public and highlight the questionable need for restraints. This education has been successful as there is a trend showing annual reduction in use.

PLAN TO ACHIEVE TARGETS :

F&PC will continue educating division employees, providers and consumers, sharing information about successful strategies, and focus resources on providers that are not showing improvement in this area. Interventions will be developed based on current information and state of the art practice standards.

OTHER FACTORS AFFECTING PERFORMANCE :

Reduction of physical restraint use has also been a federal concern and objective in recent years. With implementation of federal restraint regulation in 1987, physical restraints have successfully been reduced nationally. The federal regulations have been and continue to be revised to reflect outcomes in the areas of quality of life, dignity and improved quality of care. Freedom from restraints is an objective which falls under each of those areas. Reduction in restraint use is an area where positive results are possible, and providers, consumers and regulators are all working together to eliminate inappropriate use.

Goal 3 : To protect the public health and safety of patients and residents receiving services in licensed/certified health care providers by ensuring they conduct their activities in compliance with state and federal regulations.

Objective 3 : By the year 1997, identify health care providers that are generating significant numbers of violations in defined areas, and reduce the number of providers with repeat violations in these areas 20% by the year 2000.

Measure 1 : The annual number of providers with repeat violations in defined areas.

F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
This objective and measure are "under development"					

DEFINITION :

The idea is to identify those providers with violations that are serious in nature and widespread in the scope of the violation. F&PC further wishes to identify providers with "repeat violations" in these areas which have been identified as most important based on the scope and severity of the violations. The federal government has established a "grid" to measure the scope and severity. F&PC is just in the early phases of establishing a data system which will work with the measurement tool. "Scope" refers to how widespread a problem is, and "severity" to how serious the problem is with respect to substandard quality of care. The areas which will be measured in this objective include any deficiency under resident behavior and facility practices, quality of life or quality of care that constitutes immediate jeopardy, or a widespread potential for more than minimal harm that is not immediate jeopardy with no actual harm.

RATIONALE :

Providers receiving deficiencies and repeat deficiencies of a serious and persistent nature do provide services which result in undesirable outcomes for the recipients of those services. Identification of these providers will help F&PC target its education and corrective efforts to those facilities most in need. If problems are corrected, outcomes will improve for the recipients of those services, including improved quality of care and quality of life.

DATA SOURCE :

The source will be violations from the OSCARS and OBRA reporting systems. This information will be available from the F&PC Division, L&C Section, Minnesota Department of Health, 393 North Dunlap St., St. Paul, MN 55164-0900. As noted above, this objective and measure is still under development. A "Scope and Severity Grid" has been developed by the federal government for use as a measurement tool, however, the Division is just at the point of developing its capability to input data.

DISCUSSION OF PAST PERFORMANCE :

This is a new initiative still under development.

PLAN TO ACHIEVE TARGETS :

Developing a computerized tracking and identification system which will profile this information. Once providers are identified, appropriate education and remedial actions will be devised.

OTHER FACTORS AFFECTING PERFORMANCE :

Support from the federal government in terms of funding the activity.

Goal 4 : To ensure health and safety of consumers in health care settings, investigate complaints, perform background study checks and to take necessary actions to assure that those responsible for instances of abuse and neglect are no longer eligible to work in a health care facility.

Objective 1 : To assure that patients and residents of health care facilities receive quality care, by investing allegations of abuse, neglect, and exploitation, in a timely manner.

Measure 1 : Reduce the amount of time between initiating and completing VAA investigations by 20% over the next two years.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Total Number of VAA Complaints						
Actual	427	596	592	590e	590e	590e
Avg. # days from file to assign						
Actual	N/A	63	50	40e	32e	32e
Avg. # days from file to resolution						
Actual	195	156	157	140e	115e	115e

DEFINITION :

The Office of Health Facility Complaints (OHFC) investigates complaints filed against health care facilities and providers (nursing homes, hospitals, supervised living facilities, boarding care homes, state hospitals, home care agencies, and personal care attendants). If investigation finds that state or federal law has been violated, corrective action is taken. Such action may include the issuance of citations with the possible assessment of fines if violations are not corrected, or reporting an act of abuse committed by an employee to the Nursing Assistant Registry and/or to the Minnesota Department of Human Services (DHS), Background Study Unit, for possible disqualification for employment in a health care facility.

RATIONALE :

This measure is relevant because a fast response to, and resolution of, a complaint often has a direct and immediate impact on the health and safety of patients and residents. The faster the response, the greater the assurance of quality care and safety for those patients and residents. OHFC investigations entail interviews with patients, family members, staff, and physicians, a review of records, and an evaluation of patient care. The office works in conjunction with law enforcement agencies involving complaints of abuse or neglect under the state's Vulnerable Adults Act (VAA). Changes to the VAA in 1995 led to an increase in the number and complexity of OHFC investigations involving abuse and neglect. The VAA now includes a 60-day timeline for OHFC completion of abuse and neglect cases. There is an option for an extension of that 60 days if OHFC is unable to gather all the information necessary to resolve the complaint.

DATA SOURCE :

The source of the data is the OHFC complaint tracking database. The data was collected in September 1996, and can be obtained at the Office of Health Facility Complaints, 393 N. Dunlap St. (Central Medical Building), St. Paul. It should be noted that because the statute mandating these investigations was effective in FY95, data is not available for years prior to FY94. Also, the numbers in the chart do not reflect the entire number of complaints received by OHFC; the numbers reflect only the VAA complaints with a filed, assigned, and resolved date entered into the computer system.

DISCUSSION OF PAST PERFORMANCE :

Prior to 1991, OHFC was responsible for investigating potential violations of applicable state law. Since 1991, OHFC has also been responsible for investigating potential violations of federal law. This new dimension of OHFC's role has added new mandates and increased the scope of many of the investigations.

Complaints received by OHFC are divided into two categories: VAA complaints and general complaints. The VAA complaints are given a higher priority because they involve allegations of mistreatment of persons who, due to disability, are particularly vulnerable to their care givers. General complaints are those which do not involve allegations of abuse or neglect, but relate to conditions in a facility such as staff shortage, housekeeping, or dietary services.

There is increasing cooperation between OHFC and the Licensing and Certification Program (L&C). In early 1996, many of the general complaints that had been received by OHFC were forwarded to L&C in an attempt to address the backlog of VAA and general complaints received, to allow more time to focus on OHFC investigations of VAA complaints, and to have the L&C survey process appropriately handle those general complaints that relate to facility compliance with regulations. Because many of the general complaints received by OHFC are now being addressed by L&C, this section of the performance evaluation will focus on VAA complaints and investigations.

Prior to 1995, OHFC had responsibility for investigating allegations of abuse and neglect by nursing assistants employed in certified nursing facilities. The 1995 VAA changes require OHFC to investigate allegations of abuse and neglect by all employees in any type of health care facility. Because of those changes in the VAA, there is an increasing number of hearings resulting from abuse and neglect investigations. When there is a VAA complaint against a direct care staff person, and when OHFC substantiates abuse or neglect, OHFC notifies that staff person that he or she may be disqualified for employment by any health care facility. OHFC notifies DHS of the results of the investigation, and makes a recommendation as to whether the person should be disqualified. DHS makes a determination, and notifies the person as to whether he or she is disqualified. The person is entitled to a hearing before a DHS referee to determine if the person is to be restricted from employment in a health care facility. These hearings involve an increasing amount of preparation time with the Office of the Attorney General (which increases staff time needs and budget dollars needed for Attorney General services), and more staff time being spent providing testimony at hearings. Because more cases are going to hearings, more extensive investigations must be completed to support the OHFC findings.

PLAN TO ACHIEVE TARGETS :

OHFC expects a continued increase in the number of VAA complaints received. Accordingly, procedures have been developed to improve efficiency, accuracy, and outcomes. These include the development of protocols for investigation. OHFC plans to forward approximately 200 general complaints to the Licensing and Certification Program each fiscal year, to enable OHFC investigators to focus on the more serious abuse and neglect complaints.

OTHER FACTORS AFFECTING PERFORMANCE :

The 1995 changes to the VAA, including the "common entry point" language, have resulted in an increased intake process to review complaints and reports, to contact the mandated reporter, and other statutory requirements. All investigative staff are to be trained in accordance with the changes to the VAA. There has been a refinement of the procedures used for prioritization of cases to investigate, depending on the severity of the allegation.

Agency : HEALTH DEPT

Program : HLTH SYST & SPEC POPULATIONS

BACT : COMMUNITY HEALTH SERVICES

EXPENDITURES AND STAFFING :

	($ in Thousands)	Percent of Department
Total Expenditure	$21,681	11.63%
From Federal Funds	$1,649	
From Special Revenue Funds	$3,300	
General	$16,486	
From Gift Funds	$246	
Number of FTE Staff:	91	8.32%

GOALS :

- To ensure that Minnesota's communities and local governments are able to meet their public health responsibilities under state law. (M.S. 145A)

- To develop a coordinated health system so that efforts to improve the health of the population utilize the strengths and contributions of both the public health system and the private medical care system. (No Statutes Cited)

- To provide population-based information for the Department to support its Public Health and Health Care Reform policies and activities. (No Statutes Cited)

- To improve access to quality health care services. (M.S. 62J.09, 136A.1355-136A.1358,144.1464-144.1492)

- To provide public health-related information, data collection, analysis, and reporting services to assist in identifying health problems and in carrying out the duties of the Office of the State Registrar of Vital Statistics. (M.S. 144.211-144.227)

DESCRIPTION OF SERVICES :

The Community Health Services (CHS) division is the MDH's primary activity to ensure that Minnesota's communities and local governments are able to meet their public health responsibilities under State law. Public health in Minnesota is a complex collaborative process of shared responsibilities among state, local and regional governmental agencies. Increasingly, these responsibilities are also being shared by private health care providers and managed care organizations. Success in the system is often defined by what does not happen (a disease

outbreak is limited by quick intervention, a well is not contaminated, a person does not have to go to a nursing home, a child is not born prematurely). In order to meet these shared responsibilities, the department helps support and assist a local infrastructure in a variety of ways:

* administers a $14 million subsidy program for (50) Community Health Boards covering the state that provides approximately 8% of total revenues available for local community health planning and activities. The Boards prevent and control communicable diseases; protect the health of persons suffering medical emergencies; improve and maintain environmental health and safety; promote optimum human reproduction and child growth and development outcomes; and reduce health risk conditions or behaviors in order to prevent chronic diseases.

* provides expert resources and technical assistance to strengthen and support public health infrastructure, especially in the areas of local planning, provision and evaluation of community health services and the incorporation of core public health functions in those local agencies.

* maintains formal state and local public health policy development through the State Community Health Services Advisory Committee -- an advisory committee whose members are appointed by each of the state's 50 Community Health Boards. The advisory committee works with the commissioner and department staff to address joint state-local issues, to develop program guidelines and planning and reporting procedures, and to make recommendations regarding department policy, legislation and the continuing goals of the public health system.

* administers grant programs to (1) assist rural hospitals and their communities in developing strategic plans for preserving access to health services, or implementing transition projects to modify the type and extent of services provided by the hospital; (2) assist financially troubled hospitals in isolated areas of the state to continue operating; (3) establish community health centers in rural areas of Minnesota that are underserved by health care providers, and (4) develop and implement a health care network technical assistance program. This activity is also responsible for developing and maintaining data bases on health care personnel; conducting special studies on rural health care access issues; providing technical assistance regarding federal and state health care programs to rural communities and providers; assisting rural communities with recruitment and retention of health care providers; administering education aid for health care professionals; overseeing the administration of an interdisciplinary training program; and overseeing the administration of a Summer Health Care Intern Program.

* administers grants to establish, operate, or subsidize clinic facilities and services to furnish health care services to two traditionally underserved populations -- Indians who reside off reservation and migrant agricultural workers and their families.

* maintains a statewide birth, death, and divorce record registry in order to provide citizens with necessary documentation as well as to provide a key building block for assessing the health status of Minnesota's population and measuring the cumulative efficacy of efforts to improve that status.

* provides necessary information for identifying health problems and assisting in the design of appropriate activities to address them. Data collected includes an ongoing statewide survey of over 2,000 households on behavioral risk factors. Much of the information collected is necessary to meet reporting requirements and program priority setting needs of external agencies and organizations.

BACKGROUND INFORMATION :

MEASURE TYPES: ACTIVITIES (A), EFFICIENCY (E), OUTPUT (O), OUTCOMES (OC), OTHER DATA (OD), UNIT COSTS (UC), WORKLOAD (W)

DATA BASED ON: CALENDAR YEAR (CY), FISCAL YEAR (FY), FEDERAL FISCAL YEAR (FFY), BIENNIUM YEARS (BY)

Type	Based	Measure	1994-95	1995-96
W	FY	Birth Certificates	64,000	61,500
W	FY	Death Certificates	37,000	37,000
W	FY	Marriage Reports	33,000	33,000
W	FY	Divorce Reports	16,000	15,200
W	FY	Abortion Reports	14,000	13,500
W	FY	NCHS	103,000	100,000
W	FY	CDC	4,000	4,000
A	FY	Routine and Custom Tabulations	2,400	2,000
A	FY	Home Care Visits	1,091,565	900,000e
A	FY	Environmental Health Investigations	42,488	40,000e
A	FY	Disease Report Investigations	36,878	28,000e
A	FY	Family Health Visits	245,698	250,000e
W	FY	Number of health personnel for whom practice-related data and maintained	75,000	105,000
W	FY	Number of sites that receive direct technical assistance on applications, certifications, program benefits	200	240
W	FY	Number of technical assistance workshops presented	12	16
W	FY	Number of grant applications	30	30
W	FY	Number of loan repayment applications reviewed	60	70
A	FY	Number of special studies conducted	7	12
W	FY	Number of educational presentations to the Regional Boards	160	180
W	FY	Number of statewide Regional Coordinating Board address cost, quality and access issues	54	54

PROGRAM DRIVERS :

Health Reform. The working formula for health reform is:
(Health Reform = Health Care Reform + Public Health Reform). Health reform is driving the medical care and the public health systems to be accountable for new activities and for different populations. In light of massive system changes, local and state governments continue to redefine government responsibilities, particularly in the assurance function -- ensuring that personal health services and public health issues are clearly differentiated and each is appropriately addressed. Although the likelihood of wholesale changes in health care occurring at the national level are less likely now than they were two years earlier, the pending reduction in federal funds across a large spectrum of related programs will impact the delivery of health care services in the state.

Health reform measures in the past several years have also created new incentives for public health and private health care systems to work together to improve the health of all Minnesotans. These changes have resulted in new efforts by health care plans and providers to work together on public health goals. This change has provided the

PLAN TO ACHIEVE TARGETS :

Collaborative efforts between the Department and local health agencies will provide increased capacity for agencies to provide the core public health functions. A major statewide conference/training session and follow-up assistance around tuberculosis control and immunization improvement is already underway; additional focus on community health assessment was completed in 1994-95, with results incorporated into the 1996 Community Health Plans completed by each of the state's 50 Community Health Boards. In addition, local capacity building efforts in the area of use of data resulted in a two day conference/training session in January, 1996. The conference, Translating Data Into Policy, strengthened the ability of state and local public health agencies to carry out core public health functions and to meet their future responsibilities in a reformed health system. Participants from over 90% of local health boards learned to apply scientifically-based population health assessment activities to local and state policy planning and development. The Department is further refining its efforts to build capacity at the local level in order to address core local public health functions. Efforts will focus on population-based community assessment, planning and evaluation, with particular emphasis on the use of public health data and their link to the state's public health goals.

OTHER FACTORS AFFECTING PERFORMANCE :

Health reform will be changing the entire public health landscape as it is implemented. In addition, changes to health care and social services financing will also affect the public health system. Local government provides the majority of direct support to public health programs. State or federal decisions to further categorize funds will put pressures on local government to respond only to "funded mandates." Unanticipated disease or environmental threats can cause a substantial shifting of resources from one program to another in order to respond.

Goal 1 : To ensure that Minnesota's communities and local governments are able to meet their public health responsibilities under state law.

Objective 1 : Strengthen and support a system of cooperative partnerships among local, regional, and state organizations committed to protecting and promoting the health of the general population.

Measure 2 : Response to public health emergencies and to major initiatives.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Immunization status assessed - children						
Actual	---	---	---	---	---	---
Target	---	---	---	75,000	---	---
Flood - Water test						
Actual	1,057	---	---	---	---	---
Target	---	---	---	---	---	---
Food-Borne Outbreak						
Actual	1,700	---	---	---	---	---
Target		---	---	---	---	---
Emergency Meningitis Vaccinations						
Actual	---	---	---	---	---	---
Target	---	---	29,000	---	---	---
Meningitis Throat Swabs						
Actual	---	---	3,000	---	---	---
Target	---	---	---	---	---	---

DEFINITION :

Maintaining the public health system in a "state of readiness" to respond to initiatives and emergencies prevents death, disease and disability. In 1993 and 1994, three major events occurred to test this "state of readiness": 1) A major immunization initiative was undertaken to raise the immunization levels of all children in Minnesota. Local public health nurses and other staff quickly assessed the immunization status of the children in their area, formulated plans for universal childhood immunizations, and are now working with MDH (from those plans) to raise the state's immunization levels;
2) A worker in a circus traveling through Southern Minnesota was hospitalized with infectious Tuberculosis. The circus moved daily, which meant that the two-day lag between the TB screening and reading the results were done by several local public health agencies. Sixty-eight circus employees were located and tested. Appropriate preventive follow-up, including therapy and treatment, was initiated for those with a positive mantoux test in order to prevent further infection of workers or the public. 3) The 1993 summer floods in Minnesota resulted in potential contamination of thousands of wells. Working with local health agencies the MDH distributed 3,000 sample kits and tested over 1,000 well laboratory samples. Local health agencies distributed kits, responded to citizen inquiries, and did necessary follow-up work with the owners of wells that had been contaminated.

In 1995, three major disease outbreaks occurred which were dealt with through joint state and local efforts. In Mankato, state and local public health professionals and private health providers developed a coordinated response to a community outbreak of Neisseria meningitidis - a type of bacteria that can cause meningitis. Over a six-week period, a total of nine persons were diagnosed with the disease, 29,000 were vaccinated and given antibiotics, 3,000 throat swabs of children were collected and thousands of phone calls from concerned citizens were answered. Public health staff from 16 counties assisted at marathon immunization clinics and made it possible to effectively respond to this community outbreak.

An outbreak of group A streptococcus bacteria caused six cases of life-threatening "invasive" infections -- involving parts of the body where bacteria are not normally present, including blood and soft tissues like muscle or fat. No vaccine is available for the illness, but it can be treated effectively with common antibiotics like penicillin. Because the illness tends to progress very rapidly, it is vitally important for patients to seek treatment in a timely fashion. Olmsted, Goodhue, and Wabasha county public health staff worked with the MDH to provide information to providers and the public through a hotline, mailings to providers, and contact with local and statewide media.

Because a physician began to wonder about the number of pneumonia cases in the Mankato hospital in August, a third major community outbreak was identified in 1995. The outbreak of Legionnaires' Disease actually started sometime earlier in the summer and a similar outbreak was identified in Luverne later in August. Both outbreaks were linked to cooling towers and effective disinfection of all air conditioning cooling towers prevented further transmission of the disease. Again, local CHS staff played key roles in providing information to the public through hotlines and media activities. In addition, they helped identify the location of public and private cooling towers so disinfection could be completed throughout the community. A conference on management of cooling towers is being planned for the spring of 1996 to provide guidance on maintenance of cooling towers.

While these measurements are relatively "soft" they illustrate that positive outcomes occur through general readiness, not specific programs aimed at an infinite variety of eventualities.

DISCUSSION OF PAST PERFORMANCE :

See immediately above. In addition, local health agencies have continued their ongoing disease prevention work with the MDH. Some examples of FY 97 joint activities in investigating potential disease problems: tuberculosis in Stearns County; Hepatitis A in Polk County; anthrax in Jackson County; and numerous food-borne pathogens throughout the state.

PLAN TO ACHIEVE TARGETS :

Maintain the CHS system in a "state of readiness." The department has begun to implement a coordinated plan to deliver technical assistance to local health departments focused around public health goals and core functions. Through the State CHS Advisory Committee (SCHSAC), efforts are being focused on applying the core function framework to disease prevention and control activities. Recent SCHSAC efforts focused on identifying ways to assist CHBs to fulfill their assurance responsibilities in a managed care environment. A current SCHSAC effort is aimed at developing guidelines to assist health plans and CHBs collaborate on public health goals. In addition, another major children's immunization initiative will be undertaken through cooperative MDH, local public health agency, and private provider efforts.

OTHER FACTORS AFFECTING PERFORMANCE :

The severity and distribution of a problem is often beyond local or state control or expertise -- a local food-borne outbreak can be part of an outbreak related to a national distribution of a product, local immunization levels may fall below safe levels because of the presence of a large religious community whose beliefs preclude immunization -- planning the use of finite staff and fiscal resources for the most likely events cannot account for the unlikely or for the unforeseeable.

Goal 3 : To provide population-based information for the Department to support its Public Health and Health Care Reform policies and activities.

Objective 1 : Implementing public health reform consistent with the changes occurring in health care reform -- particularly in the area of core public health functions.

Measure 1 : Core public health functions--local use in planning.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
% use of assessment guidelines in plans						
Target		100%	100%	100%	100%	100%
% ISN/CISN plans reviewed for high risk						
Target		50%	60%	70%	80%	90%
% CHBs with all core function areas addressed						
Target		30%	45%	45%	50%	50%

DEFINITION :

Health reform is beginning to define governmental responsibilities in relation to private efforts to assure access to affordable health care by the entire population. Key to this delivery is to assess the need for prevention and emergency response activities, to develop incentives/regulations to respond to the assessment, and to implement community and statewide strategies to assure that public or private efforts to promote/protect health are in place.

Data were gathered from Washington State, from the CHS Reporting System, and from surveys (of FTEs and costs to perform core functions, completed by 8 pilot agencies in July, 1994). Additionally, Community Integrated Service Networks (CISNs) and Integrated Service Networks (ISNs) are required to plan to meet the needs of high risk/special needs populations. These plans will be coordinated with/reviewed by local public health agencies.

DISCUSSION OF PAST PERFORMANCE :

Article 7 of the 1994 MinnesotaCare Act (Minn. Laws 1994, Ch. 625, Art. 7, ?1) required a report and recommendations to the Legislature on: implementing and financing local government public health functions as well as a series of other recommendations culminating in a recommended level of "dedicated funding" for local public health. Further work done by the State CHS Advisory Committee in 1995 identified core functions and activities to be performed by state and local government public health agencies and financial resources needed to support these activities. As mentioned earlier, changes to the health system have created an opportunity and need for public health system to focus core functions of assessment, policy development and assurance, and on activities that serve the entire population. At the same time, shifts in financing threaten to erode the local public health system and compromise its ability to respond to public health emergencies. In 1996, the legislature responded in part to these concerns by allocating $1.5 million in one-time funding to counties (CHBs) participating in PMAP. The funds were intended to enable the funded counties to better perform core public health functions and to transition into a managed care environment. The funded agencies used these funds to expand population-based activities, such as population based immunization registries, community coalitions for violence prevention, and coordinated regional data systems for tracking client activities outcomes, rather than to provide health services to individuals.

PLAN TO ACHIEVE TARGETS :

In determining the Legislative recommendations, the Department, in concert with the State CHS Advisory Committee, is concentrating on core public health functions (assessment, policy development and planning, and assurance). These functions should be reflected in future local public health plans and activities and in local public health authorities' review of CISN/ISN plans to meet high risk/special needs populations.

OTHER FACTORS AFFECTING PERFORMANCE :

Shifts in Medical Assistance (MA) dollars to managed care contracts will probably result in less third party revenue for assurance activities, especially if MA funds are used to expand the uniform benefits set to substantially more people. Local collaboration among several service providers will need to recognize and act on the importance of core functions as part of an organized system that includes planning as well as service delivery.

Goal 3 : To provide population-based information for the Department to support its Public Health and Health Care Reform policies and activities.

Objective 1 : Implementing public health reform consistent with the changes occurring in health care reform -- particularly in the area of core public health functions.

Measure 2 : State-local projects to build core local public health capacity.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Number of events or projects						
Actual	1	2	1			
Target				4	10	12

DEFINITION :

A need has been identified to strengthen the ability of state and local government public health agencies to assess the health needs of the population; to plan and develop sound public health policies which are based on those assessments; and to develop programs and activities to assure that the needs are met. As the state's primary public health agency, the MDH has statutory responsibility to provide administrative and program support to local public health agencies.

DISCUSSION OF PAST PERFORMANCE :

The need for capacity building has increased in recent years as the public health system has begun to evolve pursuant to wide scale changes in the overall health system. The public health system must undertake new responsibilities and roles in order to do so. Capacity building efforts, such as the use of data in population-base community health assessment, have taken place in previous years, but have not been quantified.

PLAN TO ACHIEVE TARGETS :

Capacity building efforts over the next biennium will build on the recommendations made by a state-local Capacity Building Action Team, convened to advise the MDH on capacity building efforts; on the administrative and program support needs identified in Community Health Services Plans; and on an analysis of anticipated roles and responsibilities of public health agencies as the health system continues to evolve.

OTHER FACTORS AFFECTING PERFORMANCE :

While there is general agreement among key public health leaders about the direction that government public health efforts should move in the future, there are many issues yet to be resolved. The ability of state and local public health agencies to develop a consensus on those issues will impact performance on this measure.

Goal 3 : To provide population-based information for the Department to support its Public Health and Health Care Reform policies and activities.

Objective 2 : Accurate and useful statistical analyses for the Department of Health and other customers.

Measure 1 : A percent level of completeness and accuracy and a percent satisfied with usefulness.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Accuracy & Completeness %						
Satisfied %						
Target				80%	80%	80%

DEFINITION :

A key starting point has been to pursue the revision of the birth certificate and death certificate data sets. The death certificate revision has been completed and the birth certificate revisions are in proposed format and pilot testing will being in the beginning of 1997. The next steps will be evaluating the revisions and the overall data sets to improve completeness and accuracy. Although specific studies have been held up due to the need to focus on the revisions of the birth and death data, it is anticipated that three studies would be developed so that they would be consistent in future years in order to be able to compare year-to-year changes. One study will most likely focus on the completeness of the birth certificate data to assure the all items are completed by the health care provider. The second study will measure the accuracy of the birth certificate data by a well-established methodology developed by the National Center for Health Statistics. The third study will look at the completeness of the death certificate. In all cases there will be a strong attempt to use methodologies developed by the National Center for Health Statistics, so that we could compare Minnesota results with other states as well as with national averages.

The rationale for accurate and complete vital statistics information is clear. The usefulness of vital statistics is based entirely on whether the information is complete and accurate. Their major concern across the country is that vital statistics information is inaccurate and sometimes severely biased, based on the response and accuracy of the health care providers completing the forms. The data source for these studies would be the vital statistics data and the methodologies developed to analyze the data. The satisfaction measure is the percent satisfied among customers of the Center for Health Statistics recipients of the Center's reports and analyses, the percentage who are satisfied with the usefulness of these materials generated by the Center for Health Statistics.

The major impact of the Center for Health Statistics on improving health outcomes is the extent to which health officials can practically use statistical information to develop targeted and effective programs. The Center produces the annual summary of Health Statistics, the County Health Profiles, and Behavioral Risk Data on a statewide regional basis and other special analyses. The customers or recipients of the reports should be able to report that these materials are useful on assisting them in improving health. Due to staffing limitations, there was not the opportunity to conduct these satisfaction surveys in the past two years. It is firmly planned to conduct these surveys in 1997.

DISCUSSION OF PAST PERFORMANCE :

Minnesota has never vigorously conducted these studies in the past. There has been a reliance on the National Center for Health Statistics to conduct routine studies of this nature. Minnesota has tended to rank in the middle among the fifty states in terms of accuracy and completeness. Further analysis of the past performance will be a key initial step in the development of these accuracy and completeness studies in the future. There has not been a satisfaction survey of the customers of the Center's report.

PLAN TO ACHIEVE TARGETS :

The major activity will be to assess the nature and the scope of the accuracy in Minnesota. Once these analyses have been initiated, specific actions would be taken including the following:

* Build in edit checks into the electronic birth certificate and electronic death certificate automated systems which is integral to the 1997 legislative proposal.

* Outreach to health care providers

* Evaluate the data that is collected for reasonableness to achieve accuracy standards.

A customer service program will be initiated to develop ways in which reports can be made more useful.

OTHER FACTORS AFFECTING PERFORMANCE :

The primary contributors to accuracy and completeness are the health care providers in hospitals and personnel in the medical examiners' offices who deal with birth and death certificates. There will need to be significant collaboration with the Minnesota Medical Association, mortuaries and local registrars of vital statistics to improve accuracy and completeness of birth and death records.

Goal 4 : To improve access to quality health care services.
Objective 1 : To improve access to health care services by assisting communities to establish community health centers, receive enhanced Medicare/Medicaid reimbursement for their providers, maintain or modify hospital services, or form networks.

Measure 1 : Identification and provision of financial support to hospitals that meet the criteria of being essential to access, to the extent of available funds.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Grants Awarded						
Actual	6	7	5	6e		
Target	6	6	6	6	6	6

DEFINITION :

Under the auspices of the Sole Community Hospital Grant Program, the number of hospitals eligible for grant awards is annually determined using statutory criteria, and funding amounts are subsequently recommended to the commissioner. The data is maintained in the Office of Rural Health and Primary Care program files.

DISCUSSION OF PAST PERFORMANCE :

This program was established by the 1990 legislature. No funding was available in F.Y. 1992. In F.Y. 1993, the criteria were changed to more closely address the initial intent of the legislation, and the statute was amended to allow the commissioner to determine the amount of the award to be given to each eligible hospital based on financial need.

PLAN TO ACHIEVE TARGETS :

The program will be evaluated in FY 97.

OTHER FACTORS AFFECTING PERFORMANCE :

The total amount of funding for this program, $200,000 annually, is quite small compared to the financial losses faced by rural hospitals in recent years. The financial status of rural hospitals and need for services provided by rural hospitals are affected by many factors beyond the Office of Rural Health and Primary Care's control including Medicare, Medicaid, and private insurance reimbursement policies, as well as federal and state health care reform activities.

Goal 4 : To improve access to quality health care services.
Objective 1 : To improve access to health care services by assisting communities to establish community health centers, receive enhanced Medicare/Medicaid reimbursement for their providers, maintain or modify hospital services, or form networks.

Measure 2 : Number of hospitals that plan and/or implement projects to preserve access to care or modify hospital services to better address local need.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Grants Awarded						
Actual	10	10	7	8e		
Target	10	10	8	8	8	8

DEFINITION :

The number of hospitals that are awarded State grants through the Rural Hospital Planning and Transition Grant Program defines the measure. The intent of implementing transition projects is to modify hospital services to more effectively meet the health care needs of the community. However, this result is difficult to directly measure due to the vast number of intervening variables that could affect such an outcome. The data is maintained in the Office of Rural Health and Primary Care's program files.

DISCUSSION OF PAST PERFORMANCE :

The program was not funded for the 1991-92 grant year. In the 1992 legislative session, the program was refunded as part of the MinnesotaCare legislation. Net income loss was removed as an eligibility criterion; the maximum grant award was $50,000; administration of the program was assigned to the Office of Rural Health and Primary Care; and the appropriation was increased to $250,000 per fiscal year. The 1993 legislature corrected an error in the statutory language, which had delayed contracts in the previous year, and the maximum award was reduced to $37,500. The grant program will be evaluated in 1996.

PLAN TO ACHIEVE TARGETS :

The Office of Rural Health and Primary Care continues to administer the program and will suggest policy changes pending results of the evaluation.

OTHER FACTORS AFFECTING PERFORMANCE :

The financial status of rural hospitals and the need for services provided by rural hospitals are affected by many factors beyond the Office of Rural Health and Primary Care's control including Medicare, Medicaid, and private insurance reimbursement policies, as well as federal and state health care reform activities.

Goal 4 : To improve access to quality health care services.

Objective 1 : To improve access to health care services by assisting communities to establish community health centers, receive enhanced Medicare/Medicaid reimbursement for their providers, maintain or modify hospital services, or form networks.

Measure 3 : Number of community health centers and outreach projects established in medically underserved areas of the State.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Grants Awarded						
Actual	0	5	5	5e		
Target	10	5	5	5	5	5

DEFINITION :

The measure is defined as the number of communities/organizations that are awarded State grants through the state or federal Community Health Center Grant programs or the federal Rural Health Outreach Program. The Office of Rural Health and Primary Care awards grants through the State Community Health Center Program and provides technical assistance with preparing applications for participation in the federal programs. The program criteria are oriented toward increasing access for underserved populations, and the assumption is made that establishment of locally governed community health centers and rural outreach projects will increase access to and improve quality of care. Data is maintained in the Office of Rural Health and Primary Care's program files.

DISCUSSION OF PAST PERFORMANCE :

The State Community Health Center program was established by MinnesotaCare legislation in 1992, with an appropriation of $250,000 per fiscal year. There was no grant activity in F.Y. 1993 or F.Y. 1994, and program funding was carried over to the next fiscal year. A total of $597,250 has been awarded through the grant process through F.Y. 1996. The Office of Rural Health and Primary Care provided extensive technical assistance to entities applying for rural health outreach and federal community health center grants.

PLAN TO ACHIEVE TARGETS :

The Office of Rural Health and Primary Care will continue providing technical assistance for the state Community Health Center Program. This program will also be evaluated in F.Y. 1997.

OTHER FACTORS AFFECTING PERFORMANCE :

The availability of federal and foundation funding to supplement state funds and federal and state health care reform activities will affect this program.

Goal 4 : To improve access to quality health care services.
Objective 1 : To improve access to health care services by assisting communities to establish community health centers, receive enhanced Medicare/Medicaid reimbursement for their providers, maintain or modify hospital services, or form networks.

Measure 4 : Number of rural health care service networks formed.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Networks Formed						
Actual	N/A	15	10	10e		
Target	N/A	25	10	10	5	5

DEFINITION :

The measure is defined as the formation of a physician-hospital network, a health care provider cooperative, a health care network cooperative, a health care shared services cooperative, or a community integrated service network. The Integrated Service Network Technical Assistance Program is directed toward assisting in the formation of rural and underserved urban health care networks. Network (ISNTAP) formation is expected to improve the health care delivery system infrastructure, thereby improving access to health care and ultimately health status. However, a number of intervening variables makes these results difficult to measure initially.

DISCUSSION OF PAST PERFORMANCE :

ISNTAP was established by the 1993 legislature. In F.Y. 1994, legislation was enacted that allowed for the licensing of community integrated service networks (CISNs) as of July 1, 1994 and the immediate formation of health care cooperatives. This enabled the ISNTAP to begin providing both general and tailored technical assistance on establishing and operating community integrated service networks and health care cooperatives. The technical assistance is geared for Minnesota's communities, existing health plans and newly-developing health care networks. It is intended to help communities and organizations design creative reform strategies to enhance their health systems. Since its establishment, the ISNTAP has produced a ground breaking CISN technical assistance manual; facilitated community meetings of consumers and providers interested in developing a rural health care network; provided $200,000 in grants to five organized and presented network development technical assistance seminars across the state; conducted over 100 grant and loan searches for customers, and installed a toll-free telephone line for rural customers for site inquiries related to the formation of networks.

The 1995 Legislature deleted the earlier state policy that all Minnesotans would be in Integrated Service Networks (ISNs), Community Integrated Service Networks (CISNs) or part of the Regulated All-Payors Option. As a consequence, the formation of ISNs and CISNs by the health care industry slowed dramatically. Much of the demand for technical assistance from ISNTAP has shifted from potential CISNs and ISNs to requests for assistance from provider cooperatives as they try to establish new organizational arrangements in order to establish rural care networks.

PLAN TO ACHIEVE TARGETS :

The Office of Rural Health and Primary Care is in the process of developing a health care cooperative development technical assistance manual. Direct technical assistance is being provided, grant and loan searches are conduced weekly, and further technical assistance seminars and workshops are being planned.

OTHER FACTORS AFFECTING PERFORMANCE :

The implementation of state and federal health system reform, especially Medicare and Medicaid managed care and direct contracting, will greatly impact rural Minnesota as rural communities attempt to meet the demands of the new managed competition model. The availability of federal, state, and foundation funding will affect this program. Communities in rural Minnesota often lack the infrastructure for implementation of managed care models. Furthermore, limited resources, such as expertise, time, capital, and inexperience with capitation, puts many rural and underserved urban communities at a disadvantage as they face the challenge of transforming their locally-based, relatively fragmented health care delivery systems into ones that meet the requirements of a reformed health care system.

Goal 4 : To improve access to quality health care services.
Objective 1 : To improve access to health care services by assisting communities to establish community health centers, receive enhanced Medicare/Medicaid reimbursement for their providers, maintain or modify hospital services, or form networks.

Measure 5 : Number of sites that receive increased reimbursement for Medicare or Medicaid through participation in federal or state program.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Sites certified/designated						
Actual	15	20	18	18e		
Target	15	20	15	18	18	18

DEFINITION :

The definition is the number of sites that receive increased reimbursement through federal designation or redesignation as a Health Professional Shortage Area or certification as a Rural Health Clinic or Federally Qualified Health Center. The Office of Rural Health and Primary Care provides extensive technical assistance for entities seeking to participate in these programs. Data is maintained in Office databases.

DISCUSSION OF PAST PERFORMANCE :

This technical assistance for this program is funded through a federal Primary Care Cooperative Agreement grant.

PLAN TO ACHIEVE TARGETS :

The Office of Rural Health and Primary Care continues to publicize the availability of technical assistance and to refine its tracking mechanisms. An additional staff member was hired to provide technical assistance on reimbursement issues to community health centers.

OTHER FACTORS AFFECTING PERFORMANCE :

Availability of federal funding will determine staffing time for handling requests. State and federal health care reform has the potential for significantly changing these reimbursement mechanisms.

Goal 4 : To improve access to quality health care services.

Objective 2 : To develop and direct a statewide recruitment assistance program that identifies and targets rural and urban shortage areas, and provides information and directs recruitment/placement services to assist communities in recruiting or retaining health professionals.

Measure 1 : Number of health care professionals placed in Community Health Centers, Federally Qualified Health Centers (or look-alikes), Rural Health Clinics, National Health Service Corps or State Loan Repayment Sites, or Health Professional Shortage Areas.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Placements						
Actual	32	40	59	50e		
Target	32	40	45	50	55	60

DEFINITION :

The measure is as the number of health care professionals placed in federal and state Community Health Centers, Federally Qualified Health Centers (or look-alikes), Rural Health Clinics, National Health Service Corps or State Loan Repayment Sites, or Health Professional Shortage Areas. These entities are located in Health Professional Shortage or Medically Underserved Areas, and are prioritized for purposes of focusing recruitment assistance efforts. Although placements can be tracked, the effect of increasing the number of health professionals in shortage areas on access to service is more difficult to directly measure. Data is maintained by the office of Rural Health and Primary Care tracking system.

DISCUSSION OF PAST PERFORMANCE :

In F.Y. 1993, the Office of Rural Health and Primary Care (ORHPC) produced and distributed a recruitment and retention manual and provided recruitment and retention technical assistance through a contract with the Minnesota Center for Rural Health. The ORHPC also used federal Office of Rural Health Policy grant dollars to conduct: a statewide demand assessment for key primary care providers; two recruitment and retention workshops in rural Minnesota; and a survey of older physicians to determine their current level of medical practice and their plans for the future. In F.Y. 1994, the Nurse-Practitioner Promotion Program, which seeks to educate rural communities on the benefits of using midlevel providers, was established. The ORHPC continued to oversee the administration of the Summer Health Care Intern Program, and the State Loan Repayment Program was implemented. Under the auspices of a 15-month planning grant from the Robert Wood Johnson (RWJ) Foundation Practice Sights grant program, a practice opportunity data base was developed and information disseminated to students, residents, and practicing health professionals. The ORHPC also began collecting and entering data for the Health Personnel Database. Data on educational preparation, specialty, place of employment, and hour of practice are currently maintained on physicians, physician assistants, dentists, dental assistants, dental hygienists, licensed practical nurses, registered nurses, physical and occupational therapists, and respiratory care therapists to provide information to assist local communities and state government develop plans for the recruitment and retention of health personnel.

In F.Y. 1995 the Nurse Practitioner Promotion Team program funding ended and the program itself was discontinued due to limited interest, but the manual developed for the program remains in high demand. The manual was revised to include information about other mid-level providers. Approximately 300 of the manuals have been distributed to interested parties.

PLAN TO ACHIEVE TARGETS :

A new federal law permitted the state to recommend waivers of a two year home residency requirement for foreign medical graduates who are in the U.S. for medical residency to remain in Minnesota to practice primary care in underserved areas. The Office of Rural Health and Primary Care proposed guidelines for processing requests for waivers through the state and, using the proposed guidelines, recommended one waiver in F.Y. 1995 and six in F.Y. 1996. All seven were approved by the federal government.

In F.Y. 1995 the Office of Rural Health and Primary Care received a three year National Health Services Corp grant to develop an Interdisciplinary Fellowship program. The program provides rural, interdisciplinary study sites for teams of medical students, nurse practitioner students, and physician assistant students to learn first hand about the interaction of health professionals in a rural clinical setting. Twenty three students have participated in the first two years of the program.

OTHER FACTORS AFFECTING PERFORMANCE :

The availability of state and foundation funds to support these activities will affect performance. In addition, state health care reform activities and the salary range, working conditions, geographical location of a health care facility, and numerous other factors ultimately affect success in the recruitment and retention of health professionals.

Goal 5 : To provide public health-related information, data collection, analysis, and reporting services to assist in identifying health problems and in carrying out the duties of the Office of the State Registrar of Vital Statistics.

Objective 1 : Timely processing of vital statistics on electronic media for federal agencies and an annual summary of health statistics.

Measure 1 : Average number of days for preparing the transmission of the monthly data.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Days Turnaround						
Actual	95	90	90			
Target	90	90	80	70	70	60

DEFINITION :

The number of days after the end of the month which that month's data would be transmitted to the federal agencies. The turnaround time is required by the contract with the National Center for Health Statistics and the Social Security Administration. In addition, having the vital records data in electronic media is very important in a timely fashion for other MDH programs to identify individuals for high risk births, immunizations, outreach, etc. Data source come from internal management reports tracking the turnaround time.

DISCUSSION OF PAST PERFORMANCE :

Meeting the target turnaround time has been increasingly difficult with the existing manual system of a centralized data entry of paper birth and death certificates. The improvement in the turnaround time in FY 1994 and 1995 compared with FY 1993 has been a result of a pilot test of an Electronic Birth Certificate automated program.

PLAN TO ACHIEVE TARGETS :

The major plan revolves around the implementation of the Electronic Birth Certificate (EBC) system on a statewide basis. There will be legislation and a two-year appropriation sought for the FY 1996 and FY 1997 to implement the EBC system at state's 50 largest hospitals -- accounting for over 90% of all births.

A pilot for an Electronic Death Certificate (EDC) system is also going to be pursued. Based on the results of the EDC pilot have been assessed in the next two years, a legislative proposal is being proposed for the 1997 session which will include automated systems for death certificates.

OTHER FACTORS AFFECTING PERFORMANCE :

Developing new automated systems will require not only the support of Legislature, but also, hospitals, physicians, other health providers and mortuaries. A top priority is developing the cooperation and support by these professional groups.

Goal 5 : To provide public health-related information, data collection, analysis, and reporting services to assist in identifying health problems and in carrying out the duties of the Office of the State Registrar of Vital Statistics.

Objective 1 : Timely processing of vital statistics on electronic media for federal agencies and an annual summary of health statistics.

Measure 2 : Final report of the Summary of Health Statistics in terms of the number of months.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Months to Publish						
Actual	11	10	10e			
Target	10	10	9	9	9	9

DEFINITION :

The definition is the number of months following the end of the reporting year when the summary is published. The major report is produced by the Center for Health Statistics is the annual report entitled Minnesota Health Statistics. This report has a series of key customers including local public health agencies, medical researchers, and health program people. A major concern is the timeliness of the data being available in a final, accurate manner. By reducing the lagtime in the availability of data, health officials will be able to use the information in a more timely fashion. Data Source is an internal management report tracking the process of gathering and publishing the summary.

DISCUSSION OF PAST PERFORMANCE :

Making timely data available to policy makers has been an important priority, but is hindered by the manual processing of paper records and a data entry process near the end of the process. Processing time has remained stable at 12 months with FY 1994 being the first year to reduce the time to 11 months and down to 10 months in the past two years.

PLAN TO ACHIEVE TARGETS :

The more efficient use of automated systems will enable the data to be available for tabulation and publishing on a more timely basis. The Electronic Birth Certificate and Electronic Death Certificate will enable data to be processed in a more automated fashion, which are integral components for the legislative proposal in the 1997 session.

OTHER FACTORS AFFECTING PERFORMANCE :

In addition to the need for more automated systems, there are key data items needed from the office of the State Demographer and other state agencies which are crucial to the timely publishing of the report.

Goal 5 : To provide public health-related information, data collection, analysis, and reporting services to assist in identifying health problems and in carrying out the duties of the Office of the State Registrar of Vital Statistics.

Objective 2 : Prompt and courteous processing of birth and death records.

Measure 1 : Copies of birth and death records turnaround time in days after request.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Days Turnaround						
Actual	2	2	1e			
Target	1	1	1	.5	.5	.5

DEFINITION :

After a citizen has requested a copy of the birth or death record, the performance standard is the number of days before the copy is mailed out. In addition, when a citizen has requested a change in a birth or death certificate due to names change or originally inaccurate information, the performance standard is the number of days for a new birth or death certificate with the new information can be processed.

The Vital Statistics Record Section is responsible for processing all copies of the birth and death records for citizens who need them for passports, school registrations or other reasons. Prompt turnaround time is very important for the citizens who request the copies. Additionally, there are routine types of changes such as name changes requiring that new birth certificates be issued as replacements. Prompt turnaround time for these requests is also important to the citizens.

The data source is an automate internal fee accounting system developed in the past two years.

DISCUSSION OF PAST PERFORMANCE :

With the manual systems for processing birth and death records in Minnesota, we enjoyed an extremely outstanding record of prompt turnaround time. This has changed in recent years to some degree, because of increasing workload, staff reductions and most importantly, not identifying new or efficient processes within the unit. As a result, there has been the commitment to use more automated systems, such as the electronic birth certificate, electronic death certificate and an automated fee accounting systems for processing citizen's requests. The initial implementation of the fee accounting system has been completed and has resulted in improved turnaround time. Likewise, the same issues apply for the replacement of birth or death certificates.

PLAN TO ACHIEVE TARGETS :

The use of more automated systems such as the electronic birth certificate, electronic death certificate and a significantly enhanced fee accounting system, as well as a statewide network linked to local registrars of vital statistics will significantly enhance customer service. These proposals are being developed as part of the legislative initiative in the 1995 session of the Legislature.

OTHER FACTORS AFFECTING PERFORMANCE :

The workload fluctuates fairly significantly throughout the year based on citizens' demands. These revolve around vacation times, beginning of school and other routine events when copies of vital records are needed. In addition, significant cooperation is needed from the local registrars of vital statistics.

Agency : HEALTH DEPT

Program : HLTH SYST & SPEC POPULATIONS

BACT : FAMILY HEALTH

EXPENDITURES AND STAFFING :

	($ in Thousands)	Percent of Department
Total Expenditure	$86,435	46.38%
From Federal Funds	$77,042	
From Special Revenue Funds	$716	
General	$8,663	
From Gift Funds	$14	
Number of FTE Staff:	149	13.67%

GOALS :

- To promote optimal health and prevent diseases or conditions that are influenced by cultural norms and lifestyle choices. (M.S. 144.391-144.393; M.S. 145.9265)

- To promote the health of mothers, children, and their families. (M.S. 145.88-145.889; M.S. 144.07; M.S. 145.898; M.S. 145.90; M.S. 144.91)

- To ensure that children are wanted, safe, and supported in leading healthy and productive lives. (M.S. 145.925; M.S. 145A.15)

- To develop and implement a comprehensive state plan for the delivery of nutritional supplements and appropriate nutritional information, and develop adequate outreach activities to pregnant and lactating women, infants, and children. (M.S. 145.894)

- To develop and promote family-centered, community-based, culturally-sensitive, comprehensive systems of care for children with special health needs and their families. (M.S. 145.88-145.889; M.S. 120.1701; M.S. 144.128; M.S. 144.146)

DESCRIPTION OF SERVICES :

The Division of Family Health is responsible for ensuring optimal health outcomes for children, families, and communities. Its mission is to use science-based approaches to promote the health of all Minnesotans throughout the life cycle, by providing leadership in systems development and performance of the core functions of public

health: assessment, policy development and planing, and assurance. Activities within the Division are accomplished through collaborative partnerships with community health boards and other local, regional, and state entities.

The Supplemental Nutrition Program provides standards, technical assistance, training, grants management, program and fiscal monitoring, and related support for two supplemental nutrition programs: The Supplemental Nutrition Program for Women, Infants, and Children (WIC), and the Commodity Supplemental Food Program (CSFP) for Mothers and Children (MAC) and Nutrition Assistance Program for Seniors (NAPS). In 1995, the 68 local WIC subgrantees served approximately 98,000 participants per month, and the two local CSFP grantees served approximately 10,000 participants per month. In addition to receiving supplemental foods, program recipients received nutrition education and assistance in arranging for other needed health services.

Minnesota Children with Special Health Needs (MCSHN) is responsible for the development and promotion of systems of care for children with special health care needs that are family-centered, community-based, culturally competent, and coordinated. The program identifies, diagnoses, and treats children with known or suspected chronic illnesses or disabilities. MCSHN provides multi-disciplinary diagnostic services at clinics throughout the state, and authorizes and reimburses for diagnostic and treatment services at medical centers and health care provider offices. Staff located in district offices around the state provide technical assistance and consultative services to local community agencies, physicians and other providers, and families. MCSHN also develops and distributes educational information and sponsors professional education and training programs on topics related to children and disabilities. MCSHN provides policy analysis, and conducts and integrates research to inform and influence policy development related to children with chronic illness and disability.

The Maternal and Child Health activity strives to improve the health status of children and youth, women, and their families, by providing leadership and technical support to health care and children's service delivery systems. Local community health agencies, schools, voluntary organizations, community collaboratives, health plan companies, and other medical services providers are the primary customers. Activities include assessment of health problems of the state's population and assisting policy formulation. Technical support services are provided through program guidelines, training, technical consultation, and other support activities. In addition, the program administers the state-funded Family Planning Special Projects and the state/federal Maternal and Child Health Special Projects grant programs for provision of community-based services targeted to low-income and high-risk persons.

The oral health program provides leadership, supervision, and management in planning, developing, and implementing statewide dental public health programs. It provides professional leadership and draws together statewide resources to meet the oral health needs of the people of Minnesota and the occupational health concerns of the dental profession.

The Diabetes unit conducts comprehensive diabetes control activities based on the Minnesota Plan to Prevent Disability from Diabetes. Activities include producing an annual surveillance report on the burden of diabetes in Minnesota, supporting system-wide quality improvement demonstrations in managed care and long term care organizations, and training local coalitions to address diabetes at the community level.

The Health Education unit provides education, consultation, and training services to local public health agencies and other organizations, as well as information to the public. Special areas of expertise include community-based chronic disease prevention activities, chemical health, work site health promotion, health risk appraisals and recruitment of bone marrow donors. This unit includes a special emphasis on the prevention of Fetal Alcohol

Syndrome, Fetal Alcohol Effects, and drug-exposed infants, and tobacco control.

Nonsmoking activities focus on reducing tobacco use by changing risk conditions in the community. This is accomplished through educational and media campaigns, activity at eliminating environmental tobacco smoke, reducing tobacco advertising and promotion, reducing youth tobacco access and availability, increasing economic disincentives for tobacco use, and working with health care providers and organizations. Priority groups include: women and men in blue-collar occupations, youth, low-income and unemployed people, and persons of color.

The Injury and Violence Prevention unit integrates research, surveillance, and prevention programs across all age groups. Programs include the operation of a brain and spinal cord injury registry, the prevention of at-home injuries to children and adolescents, the prevention of injuries among the elderly due to fires and burns that occur at home, a childhood farm injury surveillance and prevention program, a bicycle helmet promotion and evaluation program, and a home visiting program designed to strengthen families and reduce risk of child maltreatment.

The Nutrition and Physical Activity unit seeks to improve health through the promotion and support of healthful eating patterns and regular physical activity. The unit provides technical support and training and consultation to local public health agencies and other organizations about nutrition and physical activity programs, information, and surveillance. The unit coordinates activities of the Minnesota 5 A Day coalition, a statewide coalition of over 60 members, with representatives from state and local health agencies, the produce industry, the media, voluntary health agencies, and other organizations, whose mission is to increase consumption of fruits and vegetables to reduce the risk of chronic diseases and promote health among Minnesotans. The unit also staffs the Minnesota Governor's Council on Physical Fitness and Sports, also a statewide coalition of 50 members with broad public and private representation.

BACKGROUND INFORMATION :

MEASURE TYPES: ACTIVITIES (A), EFFICIENCY (E), OUTPUT (O), OUTCOMES (OC), OTHER DATA (OD), UNIT COSTS (UC), WORKLOAD (W)

DATA BASED ON: CALENDAR YEAR (CY), FISCAL YEAR (FY), FEDERAL FISCAL YEAR (FFY), BIENNIUM YEARS (BY)

Type	Based	Measure	1994-95	1995-96
A	FY	No. of persons served on WIC	97,000	98,000e
A	FY	No. of persons served on MAC	4,550	3,950e
A	FY	No. of persons served on NAPS	4,685	5,954e
UC	FY	Cost per person served on WIC	$502	$540e
UC	FY	Cost per person served on MAC/NAPS	$42	$37e
A	FY	No. of WIC vendors	1,350	1,350e
UC	FY	Cost per WIC vendor	$103	$106e
OD	FY	WIC participants per vendor	72	75e
A	FY	No. of persons served through MCSHN treatment program	2,066	1,572e
A	FY	No. of persons served through MCSHN clinic program	1,101	599e

UC	FY	Cost per person served through MCSHN treatment program	$660	$760e
UC	FY	Cost per person served through MCSHN clinic program	$415	$271e
A	FY	No. of persons served MCH Special Projects grants	66,473	66,500e
A	FY	No. of persons served Family Planning Special Projects grants	117,599	117,600e
UC	FY	Cost per person served MCH Special Project grants	$121	$121e
UC	FY	Cost per person served Family Planning Special Project grants	$36	$34e
A	FY	No. of persons served by oral health program	10,250	36,037e
UC	FY	Cost per person served by oral health program	$3.07	$1.20e
A	FY	No. of clinics conducting quality diabetes projects	9	12e
UC	FY	Cost per diabetes clinic	$2,750	$2,750e
A	FY	No. of patients monitored by diabetes clinics	3,160	3,559e
A	FY	No. of on-site health education consultations	50	70e
UC	FY	Cost per on-site health education consultation	$30	$35e
A	FY	No. of telephone/e-mail health education consultations	800	1,100e
UC	FY	Cost per telephone/e-mail health education consultation	$5	$5e
A	FY	No. of health education coalitions supported	13	13e
A	FY	No. of Minnesotans reached by non-smoking activities	100,000	100,000e
UC	FY	Cost per person reached by non-smoking activities	$.25	$.25e
A	FY	No. of coalitions supported by non-smoking activities	30	32
A	FY	No. of bone marrow donors registered	3,549	5,431e
UC	FY	Cost per registered bone marrow donor	$5.34	$3.55e
A	FY	Traumatic brain injury (TBI) rate per 100,000 population	78	75e
A	FY	Spinal cord injury (SCI) rate per 100,000 population	4.0	3.9e
UC	FY	Cost per TBI/SCI case registered	$35	$35e
A	FY	Number of households in Home Visiting Program	200	277e
A	FY	No. of on-site nutrition and physical activity consultations	18	20e
UC	FY	Cost per on-site nutrition and physical activity consultation	$260	$281e
A	FY	No. telephone nutrition and physical activity consultations	1,150	1,650e
UC	FY	Cost per telephone nutrition and physical activity consultation	$12	$14e

PROGRAM DRIVERS :

Health Care Marketplace: Reforms of various elements of the health care delivery system have considerable on-going potential to significantly affect the delivery of care to women and children, including children with special health needs. These reforms or changes include: the various reforms of health insurance itself; the changes in financing, especially the increased presence of managed care in both the private and the public health insurance markets; and changes in the role of both state and local public health agencies. The ability of Family Health

programs to influence this changing environment will vary depending on the level of involvement of the program in those areas and the particular needs of the populations affected. Performance indicators, including those related to infant mortality, family planning, and access for children with special health needs, will reflect these changes in the future.

Children's System Reform: Significant energy is being directed in Minnesota at redesigning how services are delivered to children and their families. This will affect how programs are administered and how services are provided. It is critical that integration and coordination activities within and outside agencies truly simplify the delivery system, result in a system that is understandable by families and easy to access, and does not result in gaps or duplicative services.

WIC Participation: The Supplemental Nutrition Program for Women, Infants and Children (WIC) is not an entitlement program and federal funds fail to meet total needs; it is estimated that Minnesota is serving 73 percent of the eligible population. It is anticipated that federal funds will be reduced over the next several years, while the demand for WIC services is expected to continue to grow.

Importance of Lifestyle Factors: Lifestyle factors, such as diet, physical activity, smoking, and chemical use, have a significant impact on mortality and morbidity. More programs that encourage appropriate lifestyle behavior need to be developed and implemented to assure that Minnesota residents are aware of factors that may adversely affect their health and make positive changes to their lifestyles.

Aging of Children with Special Health Care Needs: It is projected that due to medical advances there has been a 100 percent increase in children with a chronic illness or disability in the last two decades. For example, survival of children with cystic fibrosis has increased sevenfold, and two times the number of children with spina bifida, leukemia, and congenital heart disease are now surviving. More than 85 percent of all children born today with a disability now survive to their 20th birthday. As a result, more attention is being paid and more efforts are being directed to the special needs of children who are transitioning into young adulthood and independence.

Continuing Increase in Single Parenthood: In Minnesota, the percentage of births to unmarried women of all races has increased from 8 percent in 1970 to 24 percent in 1994; for black births, the rate is 70 percent. Efforts to reduce unintended pregnancy, to promote male responsibility in pregnancy and parenthood, and to support children in single-parent families will become paramount in future years. Without such support, increases in children living in poverty are likely, with all of the health, social, and educational problems that frequently accompany single parenthood.

Increasing Awareness of Domestic and Community Violence as a Public Health Issue: As the public grows more aware and less tolerant of violence and abuse within families or communities, there is an increasing call for primary prevention and a recognition that a public health approach to this problem is warranted. Family Health programs are in an excellent position to develop capacity in violence prevention around existing expertise in community prevention programs, home visiting, pregnancy and parenting support, child assessment, and public and provider education.

Increasing Numbers of Children Living in Poverty: Family income is considered a good indication of child well being. The 1990 census indicated that the percentage of children living in poverty has increased almost 22 percent since 1980. There is no reason to expect that this trend has changed. Poverty plays a significant role in inadequate nutrition, poor school performance, lack of access to appropriate health care, unsafe neighborhoods, and increased risk of child abuse and neglect. Children of color are much more likely to be raised in poverty. Over 45 percent of

children of color live in poverty, with almost 70 percent of these residing in the metropolitan area. Effective strategies must be developed to adequately support children and their families, especially strategies that effectively reach communities of color.

Welfare Reform: The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 will have a significant effect on the health and well-being of Minnesota's children, families, and communities. Provisions of the act that are expected to have a particular impact on the vulnerable populations served by the Division of Family Health include: restrictions on the length of time a family will be able to receive cash assistance, exclusion of many minor parents from cash assistance, cuts to the Food Stamps and Child Care Food Programs, restriction of children's eligibility for Supplemental Security Income, cuts to the social services block grant, and restriction of services to legal immigrants.

Goal 1 : To promote optimal health and prevent diseases or conditions that are influenced by cultural norms and lifestyle choices.

Objective 1 : Adult smoking rates will be reduced.

Measure 1 : Percentage of adults who smoke.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Actual	21.7	20.4e				
Target	20.0	20.5	19.2	17.9	16.6	15.3

DEFINITION :

The adult smoking rate is defined as the percentage of persons 18 years of age and older who report being current smokers.

RATIONALE :

Smoking-related diseases, which account for more than 6,400 deaths each year, represent the leading cause of preventable mortality in Minnesota.

Measuring the percentage of adults (18 years and older) who smoke is an appropriate way of monitoring the overall impact of the combined state and federally funded program activities to reduce smoking rates. The national objective for this performance measure is 15% by the year 2000.

DATA SOURCE :

Data is collected through questions contained in the Behavioral Risk Factor Survey (BRFS). The BRFS is a random telephone survey of 3,500 Minnesotans, age 18 years and older, which is conducted throughout the year by the department.

DISCUSSION OF PAST PERFORMANCE :

In 1981, the smoking rate for all adults was 29.5%. Although men have traditionally smoked in larger proportions than women, this disparity has narrowed considerably in recent years as a result of the tobacco industry targeting of young women with special cigarette brands and sophisticated advertising campaigns. According to a 1989 survey of Minnesota women, the smoking rate for young women is approximately 35%, which is much higher than the overall adult smoking rate. Also, youth smoking is on the increase, with a 3% increase among 12th-graders between 1992 and 1995, according to the Minnesota Student Survey.

PLAN TO ACHIEVE TARGETS :

The department works with statewide and community organizations to enable them to work with youth and community leaders in adopting public policy at the community level to create conditions in the community that are supportive of youth not smoking. Additionally, the community groups work to reduce the influence of tobacco advertising and promotional products.

The department also develops and distributes posters, T-shirts, and other products with non-smoking messages, which assists in setting a community norm that smoking is harmful and dissuades or delays youth from starting to smoke. These products are then made available to schools, community organizations, and youth groups to help them accomplish their objectives.

Department staff implement these activities through a combination of grants to community groups and providing technical assistance and training for individuals and community and statewide groups.

OTHER FACTORS AFFECTING PERFORMANCE :

Smoking rates are affected by a variety of factors not directly within the department's control, including the following: product pricing and advertising decisions of tobacco companies; state and federal excise tax levels; state and local regulations that restrict youth access to tobacco products; and educational campaigns of voluntary associations such as the American Cancer Society and the American Lung Association.

Goal 1 : To promote optimal health and prevent diseases or conditions that are influenced by cultural norms and lifestyle choices.

Objective 2 : Severe periodontal disease and oral cancer will be reduced.

Measure 1 : Percentage of dental health care workers who counsel patients about tobacco use prevention and cessation.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Actual	N/A	N/A	N/A			
Target	40	45	50	55	60	65

DEFINITION :

The dental health care worker counseling rate is defined as the percentage of such workers who report counseling their patients on tobacco use prevention and cessation.

RATIONALE :

Use of tobacco products is a primary etiologic factor in the development of severe periodontal disease and oral cancer. It is important that these significant public health problems be addressed. Currently, the percentage of dental health care workers who indicate that they provide some type of tobacco prevention and cessation activity for patients is less than a third.

Few dentists, hygienists, and assistants have received formal training in tobacco cessation strategies and techniques. A majority do not believe they are adequately prepared to assist patients in quitting tobacco use. On the other hand, a large percentage of each group expresses a substantial willingness to be formally trained. These findings portray an opportunity to involve dentists, hygienists, and assistants in clinical tobacco prevention and cessation efforts. By acquiring tobacco intervention skills, dentists, hygienists, and assistants can take a leading role among health professionals in having a significant impact on the death and disability associated with use of tobacco products.

DATA SOURCE :

Data source is the 1993 Minnesota Tobacco Control Activity Survey of Dentists, Dental Hygienists, and Dental Assistants.

DISCUSSION OF PAST PERFORMANCE :

The Dental Health program has collected baseline data and promoted tobacco prevention and cessation activities with dental health care workers in cooperation with national, state, and local professional associations and government agencies.

PLAN TO ACHIEVE TARGETS :

The Dental Health program will promote tobacco prevention and cessation services by initiating educational programs, distributing educational materials, and working with all interested agencies, groups, and individuals to increase dental care workers' provision of these services to their patients. A follow-up survey is planned for 1997.

OTHER FACTORS AFFECTING PERFORMANCE :

Dental health care workers' provision of tobacco prevention and cessation services for patients is affected by a variety of factors that are not directly within the department's control, including the following: patient resistance and complaints; amount of time required; lack of reimbursement; resistance by staff; concerns about effectiveness; availability of patient education materials; and availability of adequate referral resources.

Goal 2 : To promote the health of mothers, children, and their families.
Objective 1 : Preventable morbidity and mortality in mothers and infants will be reduced.

Measure 1 : The percentage of pregnant women beginning prenatal care during the first trimester of pregnancy.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Actual	80	83e	86e			
Target	83	85	86	90	92	93

DEFINITION :

Prenatal care is defined as the health care provided during pregnancy for a woman, her unborn child, and her family, as they relate to the pregnancy. The first trimester of pregnancy is defined as the first thirteen weeks.

RATIONALE :

As a group, women who have early, continuous, risk-appropriate prenatal care have better pregnancy outcomes than those who do not. To ensure optimal pregnancy outcomes, it is critical for prenatal care to start at the beginning of pregnancy. A risk assessment done at that time can identify potential problems that can best be addressed early in the pregnancy, and the pregnant woman can be given essential health education that will prevent problems from developing.

While the department generally does not provide or fund prenatal care, through its Maternal and Child Health Block Grant, it is charged with the responsibility of assuring access to prenatal care, providing outreach to high-risk and hard-to-reach pregnant women, assuring that financial arrangements are available for paying for prenatal care, and providing wrap-around services that enable women to participate in prenatal care. This performance measure is an appropriate way of monitoring the overall effect of this program.

DATA SOURCE :

The data is obtained from the percentage of women giving birth who report receiving at least one prenatal care visit during the first trimester of their pregnancy. The number of births for which prenatal care began in each trimester of pregnancy is published annually by the department in Minnesota Health Statistics. The percentage of pregnant women beginning prenatal care during the first trimester is calculated as:

(live births for which prenatal care began in the first trimester) divided by (total live births)

DISCUSSION OF PAST PERFORMANCE :

MCH Block Grant funds have traditionally been used to strengthen outreach and educational efforts, to increase early initiation of prenatal care, to encourage compliance with prenatal care schedules based on pregnancy risk assessment, to support private providers in the areas of preparation for pregnancy and prenatal education, and to increase the adequacy of prenatal care utilization in accordance with national health objectives.

PLAN TO ACHIEVE TARGETS :

Improvement in this indicator is projected through the year 2000 due to the impact of the Maternal and Child Health Block Grant program, coupled with the considerable attention to improved pregnancy outcome that is occurring in the private sector as part of health care reform activities. For a segment of the state's population, however, this indicator may show a deterioration of status, depending upon the extent to which welfare reform policies and measures to restrict provision of services to legal and illegal aliens result in loss of access to the health care system.

OTHER FACTORS AFFECTING PERFORMANCE :

Participation in prenatal care is affected by many factors outside the department's control. These include: the number and geographic location of specialty health care providers willing to provide high-risk prenatal care; financial resources to pay for prenatal care; barriers to care, such as transportation, child care, and lack of translators; the lack of knowledge about the importance of receiving prenatal care, especially early in the pregnancy and for second or subsequent pregnancies; lack of recognition of the signs of pregnancy; and denial that pregnancy has occurred.

Goal 2 : To promote the health of mothers, children, and their families.
Objective 2 : Infant mortality rates for communities of color will be reduced to the currently relatively low rate for white infants.

Measure 1 : Disparities in infant mortality rates.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
African American infants disparity ratio						
Actual	2.4	2.2e	2.0e			
Target	2.0	1.9	1.8	1.7	1.6	1.5
Native American infants disparity ratio						
Actual	2.0	1.9e	1.9e			
Target	1.8	1.8	1.7	1.7	1.6	1.5
Asian American infants disparity ratio						
Actual	.9	1.0e	1.0e			
Target	1.0	1.0	1.0	1.0	1.0	1.0

DEFINITION :

Infant mortality rates are defined as the number of deaths to persons under one year of age per 1,000 live births.

RATIONALE :

Infant mortality is an internationally-recognized standard for evaluating child health status. While Minnesota's overall infant mortality rate is one of the lowest in the United States, the disparity between the rate for white infants and the rates among communities of color is among the highest in the country. Because the actual number of infant deaths for Minnesota in communities of color are small, five-year running averages are used for these measures.

DATA SOURCE :

The number of births and deaths by race is published annually by the department in Minnesota Health Statistics. The disparity ratio for each community of color is calculated as follows:

[(infant deaths for that community) divided by (births for that community)] divided by [(white infant deaths) divided by (white births)]

DISCUSSION OF PAST PERFORMANCE :

Local health agencies are encouraged to utilize their Maternal and Child Health Special Project grant to target minority populations. Additional funds have been made available to the cities of Minneapolis and St. Paul, where the majority of the minority population resides. These additional funds are used in large part to improve pregnancy outcomes in minority populations.

PLAN TO ACHIEVE TARGETS :

The Infant Mortality Reduction Initiative's activities have been directed at the identification of preventable, causal, and contributory factors related to mortality, and the support and implementation of effective program interventions and public policy changes aimed at preventing future infant deaths.

OTHER FACTORS AFFECTING PERFORMANCE :

The department does not directly control any of the factors that contribute to infant mortality. These include demographic, medical, physical, environmental, educational, behavioral, and attitudinal factors, as well as receipt and quality of medical care. However, the department funds many activities that address these issues through prevention efforts such as family planning, improved pregnancy outcome, immunizations, childhood injury, and family violence, funds review of infant deaths to determine the causes of preventable deaths, and develops strategies to prevent future deaths.

Goal 3 : To ensure that children are wanted, safe, and supported in leading healthy and productive lives.

Objective 1 : The proportion of pregnancies that are unintended will be reduced.

Measure 1 : The percentage of pregnancies that are unintended.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Actual	47.8	47.6e	47.5e			
Target	47	42	40	38	36	34

DEFINITION :

Unintended pregnancies are defined as those pregnancies women report they did not want (unwanted) and those they report were earlier than they wanted (mistimed).

RATIONALE :

Effective family planning and the avoidance of unintended pregnancy can improve infant health. Reducing the incidence of births to teenaged women and increasing the interval between births serve to reduce the incidence of low birth weight and infant death, and women who plan their pregnancies tend to seek prenatal care earlier than women who become pregnant unintentionally. In addition, unintended pregnancies are an underlying cause of many social problems, such as child abuse and neglect, school difficulties, poverty, and juvenile criminal activity.

DATA SOURCE :

The 1988 National Survey of Family Growth, conducted by the Centers for Disease Control, found that 32 percent of births occurring to married women and 55 percent of births occurring to unmarried women are unintended. The number of births and fetal deaths to both married and unmarried women is published annually by the department in Minnesota Health Statistics, as are the number of induced abortions and the total number of pregnancies. The percentage of pregnancies that are unintended is calculated as follows:

[(.32 x births to married women) + (.55 x births to unmarried women) + (.32 x fetal deaths to married women) + (.55 x fetal deaths to unmarried women) + (all induced abortions)] divided by (total pregnancies)

DISCUSSION OF PAST PERFORMANCE :

Family Planning Special Project grants are available to local communities to provide medical services, educational programs, parents as sex educator programs, non-directive family planning counseling programs, and outreach programs in the community.

PLAN TO ACHIEVE TARGETS :

Strong emphasis on outreach activities continues through educational materials, posters, billboards, radio spots, and targeted mailings. Funding was recently made available to begin an abstinence education program. Achievement of the year 2000 target will require expansion of resources for both abstinence education and subsidized family planning services.

OTHER FACTORS AFFECTING PERFORMANCE :

Unintended pregnancy rates are affected by many factors outside the department's control. These include: lack of knowledge among sexually active people of options to reduce unintended pregnancies; failure to translate knowledge into behavior; the willingness of individuals to seek out and use family planning services; community norms regarding sexual activity, contraception, and child-bearing by teenaged and unmarried women; and the availability of low-cost, confidential family planning services beyond those funded by the department.

Goal 4 : To develop and implement a comprehensive state plan for the delivery of nutritional supplements and appropriate nutritional information, and develop adequate outreach activities to pregnant and lactating women, infants, and children.

Objective 1 : All eligible Minnesota pregnant women, infants, and children will have access to adequate nutritious foods and their families will have access to nutrition education services, which includes community referrals, designed to prevent the occurrence of nutrition-related health problems through the Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Measure 1 : The percentage of the estimated population enrolled in WIC.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Actual	68	68	68e			
Target	67	70	75	80	85	85

DEFINITION :

The WIC participation rate is defined as the percentage of the estimated eligible population who are actually receiving benefits from the program.

RATIONALE :

Nutrition is essential for sustenance, health, and well-being. People who have adequate and appropriate nutrition are likely to be healthier and less in need of medical care. The WIC program provides nutritional counseling, supplemental foods, and health screening to the state's most vulnerable population: low-income pregnant women and children.

The WIC program serves several public health goals: it is a "drawing card" that allows local WIC agencies to connect families with other health services, and it promotes optimal birth outcomes and healthy child growth and development by providing nutritious foods and nutrition education. National studies have demonstrated that the infants of women who participate in WIC are more likely to be born healthy, and children who participate in WIC have better cognitive functioning. The percentage of the estimated eligible population enrolled is an appropriate way of monitoring the state's ability to meet the nutritional needs of its high-risk population.

DATA SOURCE :

The number of participants receiving vouchers from the WIC program is reported to the department by each local agency each month. The total for the state is calculated by the department and maintained as an unpublished record. The number of persons eligible for WIC is calculated annually by department staff using data from Minnesota Health Statistics, the census, the U.S. Department of Agriculture, and WIC program statistics; it is also maintained as an unpublished record. The percentage of the eligible population enrolled is calculated as follows:

(WIC participation in the month of June) divided by [{(three-year average of births) x (percent of Minnesota population below 185% of poverty) x (percent of pregnant women at nutritional risk) x (.75)} + {(three-year average of births) x (percent of Minnesota population below 185% of poverty) x (breastfeeding rate) x (percent of breastfeeding women at nutritional risk) x (.5)} + {(three-year average of births) x (percent of Minnesota population below 185% of poverty) x (percent of postpartum women at nutritional risk) x (.5)} + {(three-year average of births) x (percent of Minnesota population below 185% of poverty) x (percent of infants at nutritional risk)} + {(population estimate of children under age 5 minus three-year average of births) x (percent of Minnesota population below 185% of poverty) x (percent of children at nutritional risk)}]

DISCUSSION OF PAST PERFORMANCE :

As funding has increased, outreach activities have been directed at assuring that available funding has been fully utilized. WIC has increased services to pregnant women, infants, the working poor, and persons of color. The working poor currently constitute 14% of WIC participants. Minority WIC participation is 13% African American, 10% Asian/Pacific Islander, 8% Hispanic, and 4% American Indian.

PLAN TO ACHIEVE TARGETS :

The WIC program develops standards for outreach activities and provides annual administrative workshops for local WIC staff. As federal WIC funds fluctuate in the future, caseload management activities will be aimed at maintaining continuity and ensuring that services are maintained for the largest possible number of high-risk participants.

OTHER FACTORS AFFECTING PERFORMANCE :

WIC participation is affected by many factors outside the department's control. These include: the amount of federal and state funding appropriated for the program; the amount of infant formula rebate the program is able to generate; the retail cost of the food products purchased by the WIC program; the capacity of local agencies to serve increased numbers of participants; and the willingness of families to avail themselves of WIC services.

Goal 5 : To develop and promote family-centered, community-based, culturally-sensitive, comprehensive systems of care for children with special health needs and their families.

Objective 1 : All children with special health care needs (CSHCN) will have full access to family-centered, community-based, culturally-competent, coordinated health services.

Measure 1 : The percentage of estimated eligible severely disabled children receiving benefits from the Supplemental Security Income (SSI) program or the Children's Home Care Option (TEFRA) program.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Actual	52	75	77			
Target	45	60	75	60	60	60

DEFINITION :

The SSI/TEFRA participation rate is defined as the percentage of the estimated eligible population who are actually receiving benefits from the programs.

RATIONALE :

Over 421,000 children in Minnesota are estimated to be affected by a chronic health condition, with over 21,000 considered to have a severe disability.

Access to medical care is critical to meeting their basic needs. The financial impact of medical care is a much more significant barrier for these children than for the general population, because their medical needs are considerable and continuous. SSI and TEFRA are state/federal programs that have been created to address special financial needs of children with special health care needs. This performance measure is an appropriate way of monitoring the state's performance in assuring access to health services for this population.

DATA SOURCE :

The number of children enrolled in the SSI program is reported monthly by the Social Security Administration, and the number of children enrolled in Medical Assistance through TEFRA is reported annually by the Department of Human Services. The number of children in the state is obtained from the census. Studies reported in the literature have estimated the prevalence of disabling conditions among children from 1% to 30%. The department bases its estimate on a conservative study (Newacheck) that estimates that 1.5% of children have a condition that severely limits their activities. The percentage of the eligible population served is calculated as follows:

[(number of children under 18 enrolled in SSI in a specified month) + (number of children enrolled in Medical Assistance through TEFRA in a specified month)] divided by [(number of children under 18) x (.015)]

DISCUSSION OF PAST PERFORMANCE :

Over the past several years, the department has directed significant attention through workshops, technical assistance, and guidance to community resources, and the development of outreach materials to assure that children are enrolled in the most comprehensive and appropriate program available, thus removing cost as a barrier to receipt of health care. In 1995 and 1996, a research project was conducted to better understand the service and support needs of children and families using the TEFRA option for access to Medical Assistance.

PLAN TO ACHIEVE TARGETS :

The department will continue to inform families and referral sources of the availability of these programs and assist families through the application process.

OTHER FACTORS AFFECTING PERFORMANCE :

Participation in SSI and TEFRA is affected by many factors outside the department's control. These include: changes in eligibility criteria; delays in processing applications and determining medical eligibility; inadequate documentation to determine eligibility from medical care providers and schools; and the unwillingness or inability of families to seek out and accept public assistance and, in TEFRA, to make financial contributions to the cost of care. Changes to program eligibility for both TEFRA and SSI currently being implemented will change the target figures drastically in the next several years.

Goal 5 : To develop and promote family-centered, community-based, culturally-sensitive, comprehensive systems of care for children with special health needs and their families.

Objective 1 : All children with special health care needs (CSHCN) will have full access to family-centered, community-based, culturally-competent, coordinated health services.

Measure 2 : The percentage of Minnesota counties that document providing services to children with special health care needs in their maternal and child health plans.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Actual	85	89	94	94		
Target	89	89	90	90	95	95

DEFINITION :

The CSHN participation rate is defined as the percentage of Minnesota counties that choose to allocate some of their maternal and child health funding to children with special health needs.

RATIONALE :

The purpose of community health boards under state statute is to "develop and maintain an integrated system of community health services under local administration and within a system of state guidelines and standards." Through the Maternal and Child Health Block Grant, community health boards have access to funds that can be used to develop integrated systems of care for children with special health needs. The number of counties in which Maternal and Child Health Block Grant funds are used in the Handicapped/Chronically Ill component is an appropriate way of monitoring community activity in this area.

DATA SOURCE :

Every two years, each community health board in the state submits to the department a Maternal and Child Health Special Project Grant application, documenting how the funds it will receive through a formula will be used in its geographic area. This information is logged by county and maintained as an unpublished record by the department. The percentage of counties serving children with special health needs is calculated as follows:

(number of counties allocating funds to the Handicapped/Chronically Ill component) divided by 87

DISCUSSION OF PAST PERFORMANCE :

The department has provided information and technical assistance to community health boards, assisted with local interagency needs assessment, and conducted activities to increase understanding of and commitment to these children, youth, and their families.

PLAN TO ACHIEVE TARGETS :

The department will be directing additional technical assistance and support to assisting community health boards to expand into this component.

OTHER FACTORS AFFECTING PERFORMANCE :

Under state statute, the Maternal and Child Health Block Grant can be spent by most community health boards in any of four components, one of which is the Handicapped/Chronically Ill component; community health boards have complete discretion regarding which of the components they will fund. The department's ability to affect the decisions made by the boards is limited to providing guidance and setting standards. As funding sources available at the local level shift or decrease, competition for these funds will become stronger and communities will face increasingly difficult decisions for their use.

Agency : HEALTH DEPT

Program : HLTH SYST & SPEC POPULATIONS

BACT : HLTH POLICY & SYST COMPLIANCE

EXPENDITURES AND STAFFING :

	($ in Thousands)	Percent of Department
Total Expenditure	$9,603	5.15%
From Federal Funds	$779	
From Special Revenue Funds	$4,166	
Trunk Highway Funds	$1,512	
General	$2,789	
From Gift Funds	$357	
Number of FTE Staff:	81	7.38%

GOALS :

- To research and develop state policies that facilitate competition and health care cost containment. (M.S. 62J.042, 62J.2911 et seq., 62J.30 - 62J.48, 62J.69, 144.70)

- To improve the quality of health care services. (M.S. 62D, 62J.30 - 62J.48, 62N, 148B.60-71, 148C, 149, 153A, 214.13)

DESCRIPTION OF SERVICES :

The Data Analysis activity conducts data and research initiatives in order to monitor and improve the efficiency and effectiveness of health care in Minnesota. This activity includes: 1) collecting and analyzing health care data; 2) working with the Minnesota Health Data Institute to produce cost, quality, and satisfaction information for consumers; 3) collecting, analyzing and disseminating financial, utilization, and services data for acute care hospitals and freestanding outpatient surgical centers; 4) producing, disseminating and answering consumers' questions on the "Access to Health Records: Practices and Rights" notice; 5) implementing the Health Care Administrative Simplification Act; and 6) operating the computer systems to support the Health Policy & Systems Compliance Division and the Community Health Services Division within the Department of Health.

The Health Economics activity devotes effort to: surveying and analyzing conditions in the health care marketplace; researching and developing recommendations for state policies affecting the competitiveness of the market; and researching and monitoring trends in health care expenditures and prices. The role of the activity has expanded under MinnesotaCare legislation to include the following activities: to define, measure, and monitor health care

expenditures for purposes of developing, implementing, and evaluating growth limits; to conduct reviews of reports and maintain a database of major health care expenditures in excess of $500,000; to evaluate and make recommendations regarding antitrust exceptions for cooperative arrangements involving providers or purchasers; to monitor long-term care costs in the state; to develop a risk adjustment mechanism for competing health plans; to provide expertise and technical assistance to others involved in health care activities; to develop and administer a Medical Education and Research Trust Fund so that education and research activites are supported as competition erodes historical funding sources; to provide information to the public, providers, payers, purchasers, policy makers, and others to enhance understanding of health care markets and policy options; and to conduct special studies as mandated by the legislature.

The Managed Care Systems Program licenses Health Maintenance Organizations and Community Integrated Service Networks plans and provides consumer protection to the enrollees of these health plans. Policy development and communication to interested communities and groups is achieved through reports to the legislature, promulgation of rules and interpretation of law to affected parties. Financial and quality assurance audits monitor the licensed entity's compliance with financial solvency and quality of care requirements. The investigative activity receives and investigates enrollee complaints and assists other consumers who have related inquiries about managed health care. Operating changes, including certificates of coverage, premium rates for certain products and management contracts, must be submitted for review and approval. Enforcement action is taken when there is evidence of violation of state law.

The Health Occupations Program exists to assure the minimum qualifications of state-credentialed allied health practitioners and to protect health care consumers from incompetent practitioners. Quality and access to allied health care services are dependent in part on the competency and availability of practitioners qualified to provide specialized health services. The program contributes to quality and access goals of the health care system by engaging in four primary functions: occupational policy analysis; credentialing of qualified health care practitioners; investigation of consumer complaints and enforcement actions against practitioners for unprofessional and illegal conduct; and consumer and public information and education.

The Mortuary Science Program ensures compliance with the current statute and rules relating to disposition of the dead through the licensure of morticians, funeral directors, and mortuary science trainees; the registration and inspection of funeral establishments; the investigation of complaints and enforcement of regulations; and, the receipt, review and maintenance of pre-need trust fund reports. This activity was founded in 1898 by the Minnesota State Board of Health and is based on the concept fundamental to American society that the dead are properly cared for and the needs of survivors are met in a way that provides dignity to all. There are approximately 36,000 deaths per year in Minnesota.

BACKGROUND INFORMATION :

MEASURE TYPES: ACTIVITIES (A), EFFICIENCY (E), OUTPUT (O), OUTCOMES (OC), OTHER DATA (OD), UNIT COSTS (UC), WORKLOAD (W)

DATA BASED ON: CALENDAR YEAR (CY), FISCAL YEAR (FY), FEDERAL FISCAL YEAR (FFY), BIENNIUM YEARS (BY)

Type	Based	Measure	1994-95	1995-96

W	FY	Number of questions on the "Access to Health Records: Practices and Rights" notice	100	265e
W	FY	Number of computer users supported	120	130e
A	FY	Number of rulewriting projects and activities in progress	3	4e
A	FY	Number of special studies conducted	2	3e
A	FY	Number of high cost expenditures reviewed	115	60
A	FY	Licensed HMO's	10	9e
W	FY	Financial Exams Conducted	7	7e
W	FY	Quality of Care Exams	5	6e
W	FY	Enrollee Complaints Received	661	650e
W	FY	Enforcement Actions	40	30e
A	FY	Credentials Issued	988	1,089e
W	FY	Complaints Opened/Closed	188/175	187/170e
A	FY	Enforcement Actions Completed	10	17e
A	FY	Licensure - individuals	1,620	1,620e
A	FY	Funeral Establishment Permits	515	515e
A	FY	Inspection of Funeral Establishments	220	220e
OD	FY	Issuance of Notice of Orders	8	8e
W	FY	Complaints/Investigations/Violations	24	24e
W	FY	Pre-Need Trust Fund Reports	438	442e

PROGRAM DRIVERS :

Health Care Administrative Reforms in Other States and Nationally. Health care administrative reform efforts occurring at the state and federal levels have a significant influence on the administrative simplification activities within Minnesota. How the U.S. Department of Health and Human Services (DHHS) chooses to implement the administrative simplification provisions of the recently passed Health Insurance Portability and Accountability Act will significantly affect Minnesota efforts on administrative simplification. For example, DHHS is required to develop unique patient identifiers, and whatever identifier they choose for national use will in all likelihood be Minnesota's choice too.

Standardization of Public and Private Data and Data Forms. The collection of revenue, expenditure, and utilization data is critical to effective implementation of growth limits and to monitor the impact of reform on the health care market. The federal government and private sector organizations are working on a number of initiatives to obtain, use and store many types of health care related data in a more standard fashion. As these efforts continue and organizations work to comply with Minnesota's administrative simplification legislation, the data available for measuring and monitoring the health care system should improve.

Changes in the Health Care Market. Increases in health care costs have moderated since growth limits were established in Minnesota. At the same time, new ways to purchase and provide health care coverage continue to emerge in the market. Participants in the health care market must be kept informed of the new kinds of entities in order to operate effectively and efficiently, whether as providers of health care services, as consumers, or as purchasers.

Consumers. Consumers have become better educated on the use of health care benefits and have a higher expectation for the types, frequency and setting of care. This results in a greater number of requests for current

financial and quality information as well as the expectation of more consumer-friendly contract language

Credentialing Policy and Regulation. Economic incentives, market evolution to more specialized and independent delivery of health care services and a trend to using more allied health care professionals in networks, clinics and other provider organizations are motivating providers and payers to now support state credentialing and regulating of more allied health occupations. Representatives for unregulated allied health occupations continue to assert that state regulation of their professions will promote cost-effectiveness, access, quality and choice for consumers.

Goal 1 : To research and develop state policies that facilitate competition and health care cost containment.

Objective 1 : To achieve significant administrative cost savings by developing, reviewing, and recommending implementation guides for health care industry participants to use in implementing electronic commerce.

Measure 1 : The number of implementation guides recommended for use. (New Measure)

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Guides Recommended						
Actual	N/A	0	2			
Target	N/A	0	2	8	10	8

DEFINITION :

An implementation guide is a detailed technical document which allows health care industry participants to conduct core business transactions electronically. For example, the Department of Health has recommended two implementation guides which define protocols for health care providers and payers to electronically exchange health care claims information. The number of implementation guides recommended represents those implementation guides, which have been developed by national standard setting groups, reviewed by Minnesota's health care industry, adapted to our state's needs, and formally recommended by the commissioner of health.

The Minnesota legislature found that there is a need to advance the use of electronic methods of data interchange among all health care industry participants in Minnesota in order to achieve significant administrative cost savings. To make this advance, the Department of Health is charged with recommending implementation guides, which contain all necessary background and technical information required for health care industry participants to electronically implement core business transactions. The Department of Health is working jointly with the Minnesota Health Data Institute, the Department of Human Services, and private-sector payers and providers to review and develop implementation guides to meet this responsibility. This measure identifies the number of core business transactions for which statewide standards have been developed.

DISCUSSION OF PAST PERFORMANCE :

The Minnesota Health Care Administrative Simplification Act was not passed until F.Y. 1994, and therefore there is no activity prior to F.Y. 1995. In F.Y. 1995, the Department of Health and the Minnesota Health Data Institute formed a workgroup of public and private health care organizations to prioritize the review and development of implementation guides. After reviewing state and national activities, the group began developing implementation guides for providers and payers to exchange health care claims.

PLAN TO ACHIEVE TARGETS :

Health Department and Minnesota Health Data Institute staff are monitoring national activities in the development of national implementation guides. We are also continuing our work with our workgroup of health care organizations to: 1) prioritize our work in this area; 2) review national guides; 3) adapt national guides to meet Minnesota's specific needs; and 4) recommend statewide implementation guides, which are consistent with national efforts.

OTHER FACTORS AFFECTING PERFORMANCE :

To minimize the administrative burden on health care organizations operating in multiple states, it is very important that Minnesota's activity in the area of electronic commerce be consistent with national efforts. The Department of Health closely monitors the activities of the American National Standards Institute, the Workgroup on Electronic Data Interchange, the Health Care Financing Administration, and the U.S. Department of Health and Human Services. The ongoing work and direction being set by these organizations greatly affects the direction of state activities. Many of the health care organizations operating in Minnesota have a national presence. The Health Department will need to continue to follow the lead being set by these recognized national organizations.

Goal 1 : To research and develop state policies that facilitate competition and health care cost containment.

Objective 2 : To develop an integrated data system that will provide useful information about Minnesota's health care system to public officials, policy makers, providers, payers, and purchasers to assess the impact of health reform efforts in Minnesota.

Measure 1 : Aggregate financial and utilization data collected from hospitals, providers, insurers, and third party administrators (TPAs) for understanding Minnesota's health care delivery.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Number of Hospitals Surveyed						
Actual	145	155	155			
Target	145	155	155	155	155	155
Number of Providers Surveyed						
Actual	6,722	10.834	7,100e			
Target	7,500	10,000	7,000	8,100	7,200	8,250
Number of Insurers Surveyed						
Actual	166	232	232e			
Target	150	82	230	230	230	230
Number of TPAs Surveyed						
Actual	144	38	48e			
Target	55	65	50	75	100	100

DEFINITION :

The Department of Health asks hospitals, providers, insurers, and third party administrators to provide aggregate level data regarding administrative costs categorized by administrative function, medical expenditures, total paid premiums, and number of covered subscribers categorized by funding type. The number surveyed represents the number of acute care hospitals, physicians, HMOs, indemnity insurers, non-profit service corporations, and third party administrators that responded to the Department of Health 's aggregate surveys.

The data being collected presents a comprehensive view of financial dimensions within the state's health care system. The initial use of this data will be to allow public officials and policy makers to measure the impact changes in the health care system. The revenue data will be used to monitor trends in total premiums across health plans and to monitor compliance with growth limits to ensure that savings are passed on to consumers. Health care expenditure data will be used to monitor spending trends over time, to monitor compliance with the growth limits, and to refine the methodology used to determine growth limits. The administrative cost data will be used to identify functional areas where administrative dollars are spent, areas where expenses are increasing or decreasing, and areas where opportunities for administrative savings exist.

Collecting and monitoring this data will allow policy makers to better assess the impact of changes in the health care system in Minnesota. The data will identify areas within the state that require additional research and policy considerations. The data will also allow comparison between Minnesota's health care systems and national trends. When the data is collected over time the Department of Health will be able to identify and report on trends in the data. These trends will allow individual hospitals, providers, insurers, and TPAs to compare themselves to the trends and to identify areas of differentiated performance.

DATA SOURCE :

These measures were calculated using the Health Department's MinnesotaCare-related databases.

DISCUSSION OF PAST PERFORMANCE :

Most of the Department of Health's legislative mandate to collect this data was provided in the 1993 MinnesotaCare law. Prior to F.Y. 1994, this type of data was collected only for acute care hospitals and health maintenance organizations. Beginning in F.Y. 1994, all physician clinics, insurers, and TPAs were contacted and asked to respond to the Department of Health's aggregate surveys. The Department of Health continues to collect this data on an annual basis.

PLAN TO ACHIEVE TARGETS :

To improve the quality of the data collected from each of the groups, the Department of Health has been working with three workgroups, a workgroup of hospital representatives, a workgroup of providers, and a workgroup of health plan and insurance company representatives. These workgroups provide advice to the Department of Health on changes and adjustments to the survey instruments. The workgroups' recommendations have been incorporated to ensure more consistent data definitions, more meaningful functional categories, less burdensome reporting requirements, and better overall data. The Department of Health plans to continue working with the workgroups to assure that the surveys evolve to measure appropriate characteristics of an ever evolving health care marketplace.

OTHER FACTORS AFFECTING PERFORMANCE :

The standardization of data and reporting methods is a factor affecting performance. During F.Y. 1994 through F.Y. 1996, the Department of Health has been working with hospitals, providers, insurers and TPAs to better define and articulate the financial, utilization, and services data required to monitor Minnesota's health care market. After working with those groups to improve the data collected, we anticipate that a number of organizations will continue to modify and supplement how they record and store data. Organizations will also develop processes to ensure that they are capturing the type and form of data needed to improve their data reporting capabilities. The sooner organizations are able to make these changes and adjustments, the sooner the data reported to the Department of Health will improve.

Goal 1 : To research and develop state policies that facilitate competition and health care cost containment.

Objective 3 : To decrease the rate of growth of health care costs by 10% per year between 1993 and 1998.

Measure 1 : Annual rate of growth of health care expenditures.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Rate of Growth						
Actual	6.2e%	6.0e%				
Target	9.4%	8.2%	7.4%	6.4%	5.7%	N/A%

DEFINITION :

Growth limits are defined as the regional Consumer Price Index (CPI) for urban consumers, plus a specified percentage as indicated in M.S. 62J, Subd. 1. The MinnesotaCare Act of 1992 directed the Minnesota Health Care Commission to develop a cost containment strategy to decrease the rate of growth in health care expenditures by 10% per year from 1993 to 1998. One method for achieving this goal is the growth limits, which were established to bring the rate of medical inflation more in line with that of general inflation. For providers, the limits are based on revenues per appropriate denominator (e.g. encounters, patients, stays, or visits). For payers, the limits are based on expenditures per member per month. During 1995, the first year of enforcement, names of payers that exceeded the growth limits were to be published in the State Register. No payers exceeded the limits for that year, however, and a notice to that effect was published in the State Register. The first year of enforcement for providers and the first year of monetary penalties for payers will be 1996, when two-year average expenditures will be determined. Data used to determine overall growth limits is developed from aggregate data surveys and other sources. Growth limits are specified in legislation (62J.04), and are based on calendar years. Growth limits are set by January 31 of each year, after the CPI for the previous year is available.

DATA SOURCE :

The "actual" rate of growth continues to be an estimate for 1994 and 1995, because calculating this rate requires that all expenditures for health care in the state be determined. Sources for that information continue to be defined, new information is continuously collected, and estimates, even for early years are improved over time.

DISCUSSION OF PAST PERFORMANCE :

Data to set growth limits were first gathered in 1993, and continue to be collected annually. Data show that, for 1994, no payers exceeded the growth limit, so a notice to that effect was published in the State Register. Department staff are working with hospital and non-hospital providers to improve their reporting, in preparation for growth limits enforcement.

PLAN TO ACHIEVE TARGETS :

Department staff have developed the databases needed to monitor health care costs for both enforcement of the limits and other functions. Although growth limits have so far been met, the Department will continue to monitor the health care market to assure these positive trends continue.

OTHER FACTORS AFFECTING PERFORMANCE :

Almost one-third of Minnesota residents are covered under self-insured plans, which are regulated under the U.S. Employee Retirement Income Security Act (ERISA). Because ERISA prohibits the state from regulating these plans, we cannot directly affect health care spending in this sector. In addition, market forces outside the control of the Department, including consolidation and economy-wide inflation, will impact health care spending.

Goal 1 : To research and develop state policies that facilitate competition and health care cost containment.

Objective 4 : To prepare and disseminate accurate, useful information about Minnesota's health care market to policy makers and participants in the market, to facilitate health care policy-making and market competitiveness.

Measure 1 : Number of information sheets, reports, and issue papers provided to interested parties. (New Measure)

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Actual	500	1,050	6,600			
Target	N/A	N/A	5,000	11,500	15,000	15,000

Goal 1 : To research and develop state policies that facilitate competition and health care cost containment.

Objective 4 : To prepare and disseminate accurate, useful information about Minnesota's health care market to policy makers and participants in the market, to facilitate health care policy-making and market competitiveness.

Measure 2 : Number of presentations of health care market information made at the request of policy makers and other interested citizens. (New Measure)

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Actual	50	68	75			
Target	N/A	N/A	75	85	95	105

DEFINITION :

In carrying out its various responsibilities with regard to improving health care, the Department collects and analyzes a substantial amount of data related to the health care market, and carries out special studies at the direction of the legislature. In order to make this data useful to policy makers and others, it must be presented in formats that are accessible to persons with various levels of expertise and understanding of the topic. The department does this by preparing written reports as mandated by the legislature, as well as brief, in-depth reports on narrower aspects of the health care market. Printed materials are provided to individuals and groups who request them. In addition, Department staff respond to requests from interested groups around the state to provide presentations of information geared to the interests of the group.

Minnesota's health care market has been in a state of rapid and dramatic change for several years. The legislature has worked to control costs of health care and improve the quality of and access to health care services. Health care providers, purchasers, payers, and consumers have had to understand and adapt to these changes. In addition, providers and payers have been asked to assist with health care monitoring efforts by submitting annual reports of their revenues and expenditures. Making information about the health care market widely available and responding to requests for presentations of this material can help citizens to be more effective participants in the market.

DISCUSSION OF PAST PERFORMANCE :

Written materials about health care issues and MinnesotaCare were first prepared in 1993. Demand for the information has grown substantially in each subsequent year.

PLAN TO ACHIEVE TARGETS :

The Department strives to be responsive to policy makers' and the public's need for information. All requests for written materials or presentations of information will continue to be responded to promptly. In addition, as new trends emerge, we will develop analyses and make them available to interested parties.

OTHER FACTORS AFFECTING PERFORMANCE :

The number and nature of legislatively mandated studies will vary, and will impact the number of other types of information we can provide.

Goal 2 : To improve the quality of health care services.
Objective 1 : To review and regularly monitor the financial stability and contract compliance of health maintenance organizations (HMOs) and community integrated service networks (CISNs).

Measure 1 : Number of licensed CISNs, HMOS, number of regulatory activities.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Licensed HMO's						
Actual	12	11	10			
Target	N/A	11	10	9	9	9
Licensed CISN's						
Actual	0	0	4			
Target	N/A	N/A	4	4	5	6
Contract Reviews						
Actual	400	450	450			
Target	450	450	450	450	500	500
Audits						
Actual	10	10	12			
Target	12	12	12	12	14	14

DEFINITION :

The most basic form of consumer protection is the demonstrated ability of an HMO or CISN to deliver the health care services for which the enrollee has paid. It is also a fundamental protection to assure that the consumer receives an accurate and understandable evidence of coverage through which the enrollee can receive information necessary for health care delivery decisions. Regulatory authority for financial and contract review is found in MS ?62D and MR 4685. Data for measurement of this objective is recorded in the contract database and through audit reports that are kept on file.

CISNs were allowed to start operation on January 1, 1995, and it was anticipated that many of the smaller existing HMOs would convert to this new entity. CISNs differ from an HMO in that a CISN is allowed a phase-in period for financial reserves, a CISN has a more community focus, and CISNs, while required to have an active quality assurance program, are not required to submit certain quality related filings to the Department of Health for review and approval. CISNs are limited to a total enrollment of 50,000.

The oversight activity may result in corrective action or in the case of financial review, rehabilitation or liquidation.

DISCUSSION OF PAST PERFORMANCE :

The agency has worked closely with the regulated entities to assure the accurate and timely review of contract language, amendments, and financial reports. These activities have been successful as can be measured by the vigorous financial condition of HMOs, by the close scrutiny of the newly organized CISNs, and through the continuous receipt of contract related materials.

PLAN TO ACHIEVE TARGETS :

Individual financial staff members have experienced restructuring of their positions to allow the most senior auditor to focus on the financial solvency of HMOs/CISNs and less senior staff concentrate on routine oversight activities and reports. Emphasis on productivity will continue with close supervisory attention.

Contract review activities have been successfully expanded to involve more staff in the review of issue specific language. For example, the complaint investigators are now reviewing the contractual language describing dispute resolution.

Goal 2 : To improve the quality of health care services.
Objective 2 : To investigate and enforce alleged violations of standards related to quality of care, access to care and other coverage issues provided to HMO and CISN enrollees.

Measure 1 : Number of complaints, enforcement actions and resolution rates.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Written Complaints						
Actual	689	661	650			
Target	900	900	700	675	680	700
Enforcements						
Actual	40	40	30			
Target	30	30	30	30	40	40
Resolution Rates						
Actual	40%	45%	45%			
Target	N/A%	40%	40%	50%	50%	50%

DEFINITION :

Response to enrollee complaints is the core responsibility in successful consumer protection. Enrollee inquiries are received initially via telephone and involve a wide range of consumer issues. Based on the definition of a complaint found in MR 4685, those consumers who describe a potential violation of statute or rule are sent a complaint form along with a stamped, self-addressed envelope. Enrollees may also mail a written grievance directly to the Department of Health for investigation. Enforcement is the legal action initiated by the agency at the completion of an investigation which has substantiated a violation of statute or rule. While administrative penalties may be assessed, not all violations warrant such action especially if the violation is a one-time occurrence of little impact on the enrollee.

The resolution rate is determined at the completion of a complaint investigation. If the enrollee has received a fully or partially favorable outcome when measured against the enrollee's stated desired outcome, the file is coded as a favorable outcome. If the actions of the HMO or CISN are supported by the MCS section, the file is coded as an unfavorable outcome. In reviewing the resolution rate, it should be noted that the MCS Section is a neutral examiner of the issues and cannot advocate for either the HMO/CISN or the enrollee.

DATA SOURCE :

A complaint database, a telephone database and case files exist as measurement of this objective.

DISCUSSION OF PAST PERFORMANCE :

The agency has been actively involved in the areas of consumer education (telephone inquiries), which may prevent the situation from escalating into a full complaint, and complaint investigation with increasing success. A coding process at the closure of an investigation allows the agency to track the number and types of complaints. Approximately one-half of all written complaints deal with non-medical issues such as eligibility, premium rates and continuation of coverage. The remaining half deal with medical issues including prior authorization and referrals, medical necessity, and quality of care. Trend and analysis is performed regularly to assure that special examinations are initiated and conducted in a timely manner. While the agency has a great deal of medical knowledge and resources immediately available, there is capacity to contract with medical specialists for expertise and review. All matters involving urgently needed health care services are given priority assignment and typically resolved within one to eight hours. All complaints and complaint information is treated with objectivity and sensitivity so that enrollees can be assured of a thorough and thoughtful review.

PLAN TO ACHIEVE TARGETS :

The agency staff are well trained, seasoned investigators who have demonstrated the ability to efficiently and compassionately handle a wide range of enrollee issues. Plans to achieve future targets include the need to educate more enrollees about the services provided by the agency through brochures and public presentations.

Goal 2 : To improve the quality of health care services.
Objective 3 : To improve the overall competency and quality of allied health practitioners by credentialing hearing instrument dispensers, speech language pathologists/audiologists, occupational therapy practitioners and chemical dependency counselors.

Measure 1 : Number of applicants issued credentials for hearing instrument dispensing, speech language pathology/ audiology, occupational therapy and chemical dependency.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Hearing Instrument Dispensers						
Actual	350	254	284			
Target	N/A	300	300	300	310	320
Speech Language Pathologists/Audiologists						
Actual	690	734	805			
Target	N/A	700	710	800	800	800
Occupational Therapy Practitioners						
Actual	N/A	N/A	N/A			
Target	N/A	N/A	N/A	1400	1425	1450
Alcohol & Drug Counselors						
Actual	N/A	N/A	N/A			
Target	N/A	N/A	N/A	0	1000	2500
Total Credentials Issued						
Actual	1040	988	1089			
Target	1100	1000	1035	2500	3535	5070

DEFINITION :

Credentialing is one of two methods used in occupational regulation to affect the quality or competency of persons delivering health care services to Minnesotans. For example, imposition of competency testing as a prerequisite to certification as a hearing instrument dispenser in Minnesota assures that hearing aid sellers have a minimum level of knowledge and skill in the fitting and dispensing of hearing aids to predominantly elderly and vulnerable adults.

The number of credentials issued indicates the relative availability of practitioners in Minnesota. Unduly restrictive credentialing requirements may reduce consumer access to services. Unduly lenient credentialing requirements may increase the supply of practitioners, but reduce the overall competency of practitioners and quality of services.

DATA SOURCE :

All information related to status of a credential is updated daily and organized by occupation in a computerized database.

DISCUSSION OF PAST PERFORMANCE :

Indicators of actual performance reflect the level of credentialing activity for occupations currently regulated by the Health Occupations Program. As a result of new examination requirements for hearing instrument sellers, the size of the occupational group was significantly reduced. Speech-language pathologists and audiologists continue to gradually increase in numbers. Occupational therapy practitioners are registering with the Department of Health for the first time in FY 97. Licensure of alcohol and drug counselors will begin in FY 98.

PLAN TO ACHIEVE TARGETS :

Rules are being promulgated for alcohol and drug counselor licensure to establish uniform procedures and standards that will be used to operate the credentialing system. Rules assure that all applicants and persons credentialed by the program receive consistent and equal treatment. Following rule promulgation, resources must be planned, requested and acquired to implement and operate the new credentialing system.

OTHER FACTORS AFFECTING PERFORMANCE :

Establishment of credentialing systems and credentialing of alcohol and drug counselors is dependent upon promulgation of rules containing uniform and particularized credentialing procedures and standards.

Goal 2 : To improve the quality of health care services.
Objective 4 : To increase the number of complaints investigated and successfully resolved relating to unlicensed mental health providers/Office of Mental Health Practitioners (OMHP).

Measure 1 : The ratio of the number of new complaints received compared to the number of total complaints closed each fiscal year for unlicensed mental health providers.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Number of OMHP Complaints Opened						
Actual	81	90	73			
Target	N/A	90	90	80	80	80
Number of OMHP Complaints Closed						
Actual	17	57	92			
Target	N/A	20	45	95	100	100
Ratio of Closed to Opened						
Actual	.21	.63	1.26			
Target	N/A	N/A	N/A	1.19	1.25	1.25

DEFINITION :

The ratio of closed to open complaints indicates the extent to which the number of complaints closed (the product of work effort) approximates the number received (the demand for state investigation and enforcement services) in the stated time period. The program records complaint data daily, and monitors and reports complaint status monthly. Over time, the ratio may be a measure for evaluating whether the majority of consumer complaints are resolved in a reasonable time, a measure of the extent to which the level of demand exceeds the level of program output, and an indicator of whether available resources may be adequate or not sufficiently effective. The measure shows that the Office of Mental Health Practice accumulated a backlog of open complaints between FY93 and FY95 and in FY96 reduced the backlog. However, the ratio of closed to open complaints will have to continue above a target of 1.0 to further reduce the backlog of open complaints.

DISCUSSION OF PAST PERFORMANCE :

The Commissioner of Health assumed authority to investigate complaints against unlicensed mental health practitioners effective FY92. Included in the complaint data for OMHP for FY92 are approximately 60 open complaints transferred to the Commissioner from the sunsetted Board of Unlicensed Mental Health Service Providers. In FY93, the program implemented a priority scheme for determining allocation of investigatory and enforcement resources, and a greater proportion of open mental health complaints were closed. However, of those remaining, only the most egregious complaints can be investigated, and a backlog of unresolved mental health complaints has been steadily growing. In FY94, the biennial appropriation to OMHP was cut 9% while the number of complaints increased approximately 29%.

PLAN TO ACHIEVE TARGETS :

In view of the number of complaints, the current level of resources and the factors affecting performance described below, improvement in the ratio of closed to open OMHP complaints requires additional resources.

OTHER FACTORS AFFECTING PERFORMANCE :

Complex factors affect investigation and resolution of complaints in OMHP. First, about 50% of complaints allege client/therapist sexual contact. Second, evidence of violations primarily relies on client testimony as opposed to paper documents. Third, because practitioners are not credentialed by the Department of Health, each complaint requires unique investigatory effort to establish that the Commissioner has jurisdiction of the practitioner involved. The multitude of titles used and types of training and education possessed by practitioners requires frequent OMHP contact with mental health licensing boards (social work, marriage and family therapy and psychology) to determine that jurisdiction is appropriate. Finally, unlicensed practitioners, who have not acknowledged the authority of the state to regulate practice by obtaining a credential, regularly challenge jurisdiction of the Commissioner to investigate and discipline their conduct. These factors make investigation and enforcement activity very labor intensive and time-consuming.

Goal 2 : To improve the quality of health care services.
Objective 5 : To ensure compliance with current statutes and rules relating to examination and licensure of morticians, funeral directors, and mortuary science trainees.

Measure 1 : Mortuary Science enforcement/compliance activities.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Inspections						
Actual	142	300	220			
Target	300	250	250	250	300	300
Investigations						
Actual	9	10	24			
Target	N/A	10	10	10	10	10
Notice of Orders						
Actual	20	20	8			
Target	N/A	20	20	10	10	10

DEFINITION :

It is the responsibility of the Mortuary Science Program to ensure that individuals and establishments have met the requirements mandated by statute and rule for licensure. Staff is responsible for conducting inspections, investigating complaints, and providing information to the general public and licensees on requirements and regulations. The number of inspections will increase in FY 98, if the Department of Health's proposed legislation which includes the licensure of crematoriums is passed. Currently, crematoriums are not licensed. A Notice of Order is the written notice listing deficiencies to be corrected after an inspection. Establishing educational requirements consistent with national recommendations, development and supervision of a valid internship program, as well as the implementation and utilization of valid licensing examinations are methods used to ensure quality services to the citizens of Minnesota.

DATA SOURCE :

Information is stored in the Mortuary Science database and other records.

DISCUSSION OF PAST PERFORMANCE :

Minnesota is recognized as a leader in funeral services. The constant influx of individuals seeking licensure and a minimal number of complaints and/or violations indicate the program has worked well. The ongoing effectiveness of the program requires regular review of the statute and rule which regulates the industry and continuous consultation to the licensees and public. The number of applicants for individual and establishment licensure, combined with the renewals, dictates the program's activity.

PLAN TO ACHIEVE TARGETS :

Maintaining the health, safety and welfare of the licensees has become more complex with the addition of many new regulations, in the areas of itemization of charges, infectious waste, occupational safety and health, and blood-borne pathogens, all of which create an increased demand for information. Compliance with these regulations is mostly facilitated through working cooperatively with licensed funeral establishments. Review and development of more consistent, comprehensive establishment permit requirements needs to be considered. With limited staff and other resources, the usual high level of service can be greatly impacted by a single factor such as a media investigation.

Agency : HEALTH DEPT

Program : HEALTH PROTECTION

BACT : PUBLIC HEALTH LABORATORIES

EXPENDITURES AND STAFFING :

	($ in Thousands)	Percent of Department
Total Expenditure	$5,388	2.89%
From Federal Funds	$820	
From Special Revenue Funds	$2,460	
General	$2,106	
From Gift Funds	$2	
Number of FTE Staff:	86	7.87%

GOALS :

- To meet the laboratory service needs of Department of Health Programs, including acute and chronic disease surveillance and control, newborn metabolic disease screening, public water supply monitoring, and environmental program needs of other state agencies and local units of government. (M.S. 144.05, 144.125, 144.0742, and 144.381)

- To help assure the quality of tests performed by other laboratories for state environmental monitoring programs. (M.S. 144.97-98)

DESCRIPTION OF SERVICES :

The Public Health Laboratory (PHL) activity performs physical, chemical and radiological analyses on environmental materials such as air, water, sludge, wastewater, sediment, soil, tissue and toxic and hazardous substances for Minnesota Department of Health programs, the Pollution Control Agency, Department of Transportation, Department of Labor and Industry, local units of government, and several federal agencies; performs tests on human and animal specimens for infectious, chronic, and hereditary diseases as an integral part of the disease surveillance, prevention and control programs managed by the Department and local health agencies; performs selected clinical laboratory tests for private and public health care providers, including reference and verification testing; and manages a certification and quality assurance program for other public and private laboratories which perform tests for Minnesota environmental monitoring programs. The Laboratory also develops new test methods, adapts existing methods to new laboratory sample and specimen types, participates in regional and federal surveillance activities, and pursues the use of new and more efficient test methodologies. The Laboratory also provides technical consultation to programs, and other health professionals.

BACKGROUND INFORMATION :

MEASURE TYPES: ACTIVITIES (A), EFFICIENCY (E), OUTPUT (O), OUTCOMES (OC), OTHER DATA (OD), UNIT COSTS (UC), WORKLOAD (W)

DATA BASED ON: CALENDAR YEAR (CY), FISCAL YEAR (FY), FEDERAL FISCAL YEAR (FFY), BIENNIUM YEARS (BY)

Type	Based	Measure	1994-95	1995-96
OD	FY	Chemical Laboratory Programs Served	68	66
W	FY	Chemical Laboratory Tests	74,443	86,586
W	FY	Clinical Laboratory Tests	474,782	470,342
W	FY	Environmental Labs Certified	228	237
W	FY	Samples and Specimens Processed	226,709	231,854

PROGRAM DRIVERS :

The Laboratory workload is likely to remain the same for a variety of reasons: increases in the incidence of sexually transmitted diseases; emerging infectious disease problems, such as new organisms, and parasitic organisms in public water supplies; redirection of federal resources away from providing or supporting laboratory services; and public water supply monitoring reductions. With health reform, we expect shifts in the Clinical Laboratory workload, as some screening tests may be done in private sector laboratories, while other types of tests, e.g., reference or confirmatory testing now performed in the private sector may come to the Minnesota Department of Health.

Increasing costs of tests, along with costs to upgrade facilities may cause some government laboratories to become specialized centers of excellence to perform high cost, low-demand tests in certain testing categories.

Goal 1 : To meet the laboratory service needs of Department of Health Programs, including acute and chronic disease surveillance and control, newborn metabolic disease screening, public water supply monitoring, and environmental program needs of other state agencies and local units of government.

Objective 1 : The number of new applications of state-of-the art, DNA-based molecular methods for rapid detection and identification of infectious agents will be increased by at least five each year.

Measure 1 : Number of additional communicable disease agents which are tested using DNA-based molecular methods.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance Number of additional agents tested using DNA methods						
Actual	14	14	12			
Target	5	5	5	5	5	5

DEFINITION :

The measure is a good indicator of the rate of progress the Clinical Laboratory is making in implementing state-of-the-art methods in testing for infectious disease causing agents. This objective and measure are related, but more specifically defined, than the Objective 1 presented in the 1994 Annual Performance Report for the Public Health Laboratory Division.

RATIONALE :

New DNA-based methods give the Laboratory the ability to detect more quickly and specifically current and emerging infectious microorganisms that threaten the health of Minnesota citizens. Ongoing application of this new methodology to additional agents of infectious disease is cost-effective, it broadens the Laboratory's capacity to support state-of-the-art molecular epidemiology, and it ensures that the Laboratory continually meets the changing needs of the programs it serves.

DATA SOURCE :

Numbers of new method applications per fiscal year are obtained directly from the computerized data base of the Public Health Laboratory Division.

DISCUSSION OF PAST PERFORMANCE :

In the past, laboratory tests to detect and identify infectious agents depended on the use of time consuming, traditional microbiologic methods. While the use of such traditional methods continues to be essential, in 1993 the State Legislature appropriated funds to develop the Laboratory's capacity to apply new molecular DNA-based methods. Implementation of these new methods now gives the Laboratory the ability to detect and identify food borne, water borne, community acquired, and institutionally acquired infectious diseases more rapidly and with cost-effective precision. This ability markedly improves the focus of epidemiologic investigations that lead to the prevention and control measures needed to protect the public's health.

PLAN TO ACHIEVE TARGETS :

Since the initial implementation of DNA-based molecular methods to diagnose tuberculosis, the Laboratory has applied these methods to detect and investigate outbreaks caused by salmonella, E. Coli 0157, meningococcus, and other harmful infectious agents. As needs continue to arise, based on outbreak investigations, acute disease surveillance activities, and reference identifications, which are core functions of the Laboratory, these and other new methods will be applied to other infectious organisms. This will include infectious bacteria, viruses, protozoa, molds, and yeast. It will include those agents commonly associated with outbreaks and those that pose emerging public health threats.

OTHER FACTORS AFFECTING PERFORMANCE :

Achieving the target may be affected by availability of adequate core funding for needed staff, equipment, and supplies.

Goal 1 : To meet the laboratory service needs of Department of Health Programs, including acute and chronic disease surveillance and control, newborn metabolic disease screening, public water supply monitoring, and environmental program needs of other state agencies and local units of government.

Objective 2 : Satisfy chemical laboratory client needs by keeping price increases at less than the estimated inflation rate of 3% and reporting test results within the times negotiated with individual clients.

Measure 1 : An average bench hour rate used to calculate laboratory test prices.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Performance						
Average bench hour rate						
Actual	89.18	89.18	89.66			
Target	N/A	N/A	92.00	93.00	93.00	94.00

DEFINITION :

Measures 1 is designed to show improvements in the efficiency of the chemical laboratory.

Measure (1) represents efforts at cost control. Bench hour rate includes all identifiable expenses over which the laboratory staff has control, including costs related to testing, reporting of results, necessary support services, and management.

RATIONALE :

Clients expect the prices they pay to be based on maximally efficient operations, which the Laboratory strives to achieve. On the other hand, state law requires that test prices must be set so as to generate the amount of revenue required to cover the costs of providing the service.

DATA SOURCE :

Public Health Laboratory database.

DISCUSSION OF PAST PERFORMANCE :

Since F.Y. 1991, the percent change in the average bench hour rate has remained well below that of inflation, due to ever more precise adjustments in staff levels to match the workload.

PLAN TO ACHIEVE TARGETS :

Staff levels are constantly evaluated and adjusted to match workloads, so that salary costs are kept to a minimum. This is accomplished by utilizing part time, seasonal, or temporary positions. New accounting software is facilitating the tracking of purchases and costs. In addition, staff are reminded of the need to practice cost containment at every step in the process of incurring expenditures. Whenever new or replacement equipment is being considered, the increased efficiency of updated analytical methods is a major consideration in how equipment money is spent. Whenever it is possible, methods are updated to more efficient, less time consuming procedures.

OTHER FACTORS AFFECTING PERFORMANCE :

Larger than expected salary increases due to inflation could cause prices to be higher than was planned.

Goal 1 : To meet the laboratory service needs of Department of Health Programs, including acute and chronic disease surveillance and control, newborn metabolic disease screening, public water supply monitoring, and environmental program needs of other state agencies and local units of government.

Objective 2 : Satisfy chemical laboratory client needs by keeping price increases at less than the estimated inflation rate of 3% and reporting test results within the times negotiated with individual clients.

Measure 2 : Percent of test results reported within negotiated reporting times.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Performance % reported on time						
Actual	83.7	85.1	94.8			
Target	N/A	100	100	100	100	100

DEFINITION :

Measures 2 is designed to show improvements in the efficiency of the chemical laboratory.

Measure (2) demonstrates how well the Chemical Laboratory is meeting one of the most significant matters of concern to clients, that for receiving test results within a reasonably achievable time.

RATIONALE :

Measure (2) indicates that particular attention is being paid throughout the laboratory to assure that results reach the client in time, whether by hard copy or by making data accessible through electronic media. Clients are notified ahead of time if a delay beyond the negotiated time is expected.

DATA SOURCE :

Public Health Laboratory database. Measure (2)-Data has been modified from the 1994 performance report to reflect changes in the method of measuring.

DISCUSSION OF PAST PERFORMANCE :

In the past the timeliness of data reporting was not a high priority. Ever shorter turnaround times have been agreed to by the laboratory for each of the past few years.

PLAN TO ACHIEVE TARGETS :

Turnaround time is monitored weekly to assure that results will be produced in time and analysts are apprised of the need for special effort when deadlines are approaching. Equipment failures are kept to a minimum with preventive maintenance and equipment service contracts.

OTHER FACTORS AFFECTING PERFORMANCE :

Large, unplanned increases in a workload can have a negative affect on the laboratory's ability to meet the reporting time criterion.

Goal 2 : To help assure the quality of tests performed by other laboratories for state environmental monitoring programs.

Objective 1 : Increase laboratory participation in the certification program by 2% per year.

Measure 1 : Number of laboratories participating in the certification program.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Performance Number of labs participating						
Actual	221	228	237			
Target	221	230	237	240	245	250

DEFINITION :

This measure is the number of laboratories participating in the program.

RATIONALE :

Under M.S. 144.98, laboratories may participate in the certification program implemented by the Health Department. Governmental programs which use environmental data can require the use of certified laboratories. There are an estimated 300 laboratories providing environmental monitoring services for Minnesota programs.

Increasing the number of labs participating in a certification program and assuring they meet minimum standards helps improve the quality of data from these environmental laboratories.

DATA SOURCE :

Public Health Laboratory database.

DISCUSSION OF PAST PERFORMANCE :

The certification program began in 1988. When the statute was first passed, rules were adopted which allowed the phasing in of test categories. The first laboratories began the application process in 1989 with approximately fifty enrolling. In 1996, the Minnesota Pollution Control Agency began requiring the use of certified laboratories in its Groundwater and Solid Waste and Hazardous Waste Programs.

PLAN TO ACHIEVE TARGETS :

Actively encourage state and local environmental monitoring programs to require the use of certified laboratories.

OTHER FACTORS AFFECTING PERFORMANCE :

Since the previous report, a consensus among the fifty states was reached to move forward with a national accreditation program providing reciprocity among all the states. National reciprocity could reduce the number of out-of-state laboratories (currently 45) participating in the program. However, implementation of the national program is several years out.

Goal 2 : To help assure the quality of tests performed by other laboratories for state environmental monitoring programs.

Objective 2 : Sponsor a minimum of 2 training activities per year for public and private laboratories in Minnesota.

Measure 1 : Number of training activities.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Performance Number of training activities						
Actual	N/A	N/A	N/A			
Target				1	2	3

DEFINITION :

Measure reflects training activities promoted by the program.

RATIONALE :

Under M.S. 144.98, laboratories may participate in the certification program implemented by the Health Department. Governmental programs which use environmental data can require the use of certified laboratories. The department has implemented a "blind" proficiency testing (PT) program which better measures the quality of data generated by the laboratories operating under routine conditions. This PT information, as well as on-site and other surveys, will help direct training activities to areas in which deficiencies occur.

Providing training opportunities that demonstrate proper techniques used in the methods and increasing the knowledge base of environmental laboratorians should improve the quality of data.

DATA SOURCE :

Public Health Laboratory database.

DISCUSSION OF PAST PERFORMANCE :

Training activities were authorized in the 1996 legislative session, and are in a development phase during 1997.

PLAN TO ACHIEVE TARGETS :

Implement, coordinate and offer training sessions. Identify other training resources and apply as appropriate to this program.

OTHER FACTORS AFFECTING PERFORMANCE :

Downsizing of private sector laboratories caused by reduced federal monitoring requirements, tougher competition between laboratories and other industry factors may affect participation by private laboratories in training activities. The national accreditation effort may provide training opportunities and PT studies which will compete for the same group of laboratories the Minnesota program would hope to attract.

Goal 2 : To help assure the quality of tests performed by other laboratories for state environmental monitoring programs.

Objective 3 : A minimum of 2 "blind" proficiency (PT) studies will be conducted per year.

Measure 1 : Number of "blind" proficiency testing (PT) studies conducted.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Performance						
Number of PT studies						
Actual	N/A	N/A	N/A			
Target				1	2	2

DEFINITION :

Measure is the number of PT studies sponsored by the Department.

RATIONALE :

Under M.S. 144.98, laboratories may participate in the certification program implemented by the Health Department. Governmental programs which use environmental data can require the use of certified laboratories. The department has implemented a PT program which better measures the quality of data generated by the laboratories operating under routine conditions. This PT information as well as on-site and other surveys will help direct training activities. There are an estimated 300 laboratories providing environmental monitoring services for Minnesota programs.

DATA SOURCE :

Public Health Laboratory database.

DISCUSSION OF PAST PERFORMANCE :

Proficiency Testing activities were authorized in the 1996 legislative session, and are in a development phase during 1997.

PLAN TO ACHIEVE TARGETS :

Implement, coordinate and offer training sessions and PT studies. Identify other training resources and apply as appropriate to this program.

OTHER FACTORS AFFECTING PERFORMANCE :

Downsizing of private sector laboratories caused by reduced federal monitoring requirements, tougher competition between laboratories and other industry factors may affect participation by private laboratories in training activities. The national accreditation effort may provide training opportunities and PT studies which will compete for the same group of laboratories the Minnesota program would hope to attract.

Agency : HEALTH DEPT

Program : HEALTH PROTECTION

BACT : ENVIRONMENTAL HEALTH

EXPENDITURES AND STAFFING :

	($ in Thousands)	Percent of Department
Total Expenditure	$16,121	8.65%
From Federal Funds	$4,539	
From Special Revenue Funds	$541	
General	$11,041	
Number of FTE Staff:	205	18.74%

GOALS :

- To protect the public health in the use and consumption of water in Minnesota. (M.S. 103I; 144.05; 144.383; 326.37-65)

- To protect the public health by reducing exposure to environmental health hazards, such as asbestos, lead, radon, environmental tobacco smoke, chemical releases, and other toxic agents by assessing health risks, communicating health risk information and regulation of abatement. (M.S. 103H.201; 116D; 144.05; 144.12; 144.411-417; 144.871-879; 326.70-81; 473.845)

- To protect the public health by identifying and reducing the number of critical violations that cause foodborne illness, waterborne disease, communicable disease and to assure sanitary conditions in Minnesota. (M.S. 144.71-144.76; 144.12, subd. 1-2; 145.02; 145A.07; 157; 214.13, subd. 1, 3; Chapter 327.10-327.28)

- To protect the public health by reducing unnecessary radiation exposure to the public and users of ionizing radiation sources in Minnesota. (M.S. 4.035, subd.2; 12.13; 144.05; 144.121)

DESCRIPTION OF SERVICES :

The Environmental Health Division protects the public health and safety from threats in the home, community, and workplace environment. It provides this protection through enforcement of state and federal standards; provision of technical consultation with local health agencies, the regulated community, and other state agencies; evaluation of potentially health-threatening environmental conditions; and provision of health education materials concerning environmental health risks to the public, health care providers, and local health agencies.

The Drinking Water Protection Section: enforces the federal Safe Drinking Water Act and monitors public water supply systems; regulates wellhead protection plans for public water supply systems; regulates well construction, sealing, and maintenance; enforces the state plumbing code; and reviews public water supply construction plans, plumbing plans for public building construction, and swimming pool design plans.

The Environmental Health Services Section: licenses, inspects and sets standards for food, beverage, and lodging establishments and other public facilities including manufactured home parks, recreational camping areas, youth camps, migrant labor camps, swimming pools in licensed establishments, and mass gatherings; investigates foodborne and waterborne disease outbreaks; enforces the Minnesota Clean Indoor Air Act (MCIAA) in licensed public establishments; evaluates delegated local program activity to ensure standards are being met; and registers and maintains a statewide registry of environmental health specialists/sanitarians.

The Radiation Control Section: regulates x-ray equipment and all sources of ionizing radiation; approves mammography screening programs; collects and analyzes milk, water, soil, and air samples to evaluate environmental radiation levels and the effectiveness of radioactivity control procedures; and assures availability of trained staff to determine protective action guidelines in the event of a nuclear power plant emergency.

The Environmental Health Hazard Management Section: regulates asbestos and lead abatement; ensures compliance with the MCIAA and standards for the indoor air quality of enclosed sports arenas; assesses human exposure to environmental contaminants near federal Superfund sites, clean-up sites, and metropolitan area landfills; analyzes health risks as part of the environmental review process; develops health-based standards for air and groundwater contaminants; develops health effects advice related to eating sport fish from Minnesota rivers and lakes; conducts case-by-case health risk assessments at the request of state and local agencies; and provides health education materials on radon, MCIAA, indoor air quality, lead, and health risks to the public, health care providers, and the regulated community.

BACKGROUND INFORMATION :

MEASURE TYPES: ACTIVITIES (A), EFFICIENCY (E), OUTPUT (O), OUTCOMES (OC), OTHER DATA (OD), UNIT COSTS (UC), WORKLOAD (W)

DATA BASED ON: CALENDAR YEAR (CY), FISCAL YEAR (FY), FEDERAL FISCAL YEAR (FFY), BIENNIUM YEARS (BY)

Type	Based	Measure	1994-95	1995-96
A	FY	# of public water suppliers	9,000	9,000
W	FY	# of sanitary surveys	2,250	2,250
W	FY	# of samples collected	110,000	100,000
W	FY	# of water operators certified	2,000	2,000
W	FY	# of communities with wellhead protection	46	80
W	FY	# of plans reviewed for swimming pools, plumbing, sewage treatment, manufactured home parks, and camping areas	2,686	2,509
W	FY	# of plumbers and water conditioning installers licensed	5,390	5,355

W	FY	# of plumbers' apprentices registered	862	493
W	FY	# of wells inspected	3,295	3,392
W	FY	# of well disclosures processed	32,230	22,805
W	FY	# of wells sealed	11,870	11,795
W	FY	# of well contractor licenses issued	669	639
W	FY	# of technical assistance requests for wells	25,000	25,000
W	FY	of establishments inspected	3,369	4,230
W	FY	# of construction plans reviewed	516	400
W	FY	# of in-service training sessions provided	18	20
A	FY	# of delegation agreements with local agencies	48	61
A	FY	# of local program evaluations	16	16
A	FY	# of environmental health specialists/sanitarians registered	287	319
W	FY	# of environmental samples	250	250
W	FY	# of x-ray facilities inspected	1,192	850
A	FY	# of indoor air inquiries/complaints	20,000	12,000
A	FY	# of MCIAA inquiries/complaints	10,000	3,600
W	FY	# of total enclosed sports arenas/total inspected	175/150	180/85
W	FY	# of asbestos abatement project permits issued	1,223	1,144
W	FY	# of residential asbestos abatement project permits issued	957	972
A	FY	# of asbestos abatement site inspections	730	180
W	FY	% of asbestos abatement site inspections	33%	9%
W	FY	# of asbestos abatement contractors licensed	161	153
W	FY	# of asbestos abatement workers certified	647	628
W	FY	# of asbestos abatement site supervisors certified	968	1,122
A	FY	# of health risk limits (rules) for groundwater	121	121
A	FY	# of lakes and rivers in advisory	543	632
A	FY	# of advisories distributed	20,156	30,176
A	FY	# of brochures and fact sheets distributed	28,333	37,710
A	FY	# of lead-related telephone inquires	10,000	12,000
A	FY	# of lead-related presentations	40	32
W	FY	# of lead-related educational items provided	150,000	100,000
W	FY	# of reported patients tested for blood lead levels	42,306	39,828
W	FY	# of reported blood lead analyses	47,375	45,293
W	FY	# of lead abatement contractor licenses issued	165	175
W	FY	# of lead abatement inspector licenses issued	240	245
W	FY	# of lead abatement workers certified	79	57

PROGRAM DRIVERS :

Federal Regulation

The federal Safe Drinking Water Act (SDWA) continues to regulate additional drinking water contaminants at lower levels. Many of these contaminants are naturally occurring in water and are not necessarily the result of poor disposal or handling practices. Pollution prevention activities, therefore, will not affect the levels of all contaminants in the water. An increasing number of public water supplies will exceed drinking water standards as

Goal 1 : To protect the public health in the use and consumption of water in Minnesota.
Objective 1 : To reduce public exposure to drinking water contaminants in Minnesota public water supply systems.

Measure 1 : Percent of community and nontransient water supply systems in compliance.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Actual	80%	77%	79%			
Target		82%	82%	85%	90%	90%

OTHER FACTORS AFFECTING PERFORMANCE :

General aging of public water supply systems will impact their ability to meet compliance requirements. The requirement to develop wellhead protection measures for new public water supply wells, as well as public water supply systems that use surface water, should decrease potential for contamination.

Goal 1 : To protect the public health in the use and consumption of water in Minnesota.
Objective 1 : To reduce public exposure to drinking water contaminants in Minnesota public water supply systems.

Measure 2 : Percent of noncommunity transient water supply systems in compliance.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Actual	80%	80%	90%			
Target		80%	82%	85%	85%	85%

DEFINITION :

Compliance with the Safe Drinking Water Act (SDWA) rules means that a public water supply system meets all requirements of the rule including monitoring, maximum contaminant levels, record keeping, and public notification. Community and nontransient water supply systems in compliance with federal SDWA standards will be increased to 85 percent by year 2000. Noncommunity transient water supply systems in compliance with federal SDWA standards will be increased to 90 percent by year 2000. A public water supply is a piped water system that serves at least 25 persons per day for at least 60 days per year. A community public water supply serves year-round residents (municipalities, manufactured home parks). A nontransient public water supply serves the same nonresident population on a regular basis (business, schools). A noncommunity transient public water supply serves transient populations (restaurants, hotels). A primacy agreement refers to the delegation of enforcement authority from the U.S. Environmental Protection Agency (EPA) to the state of Minnesota for federal safe drinking water standards. Safe drinking water standards (maximum contaminant levels) are established by the EPA and adopted by reference and enforced by MDH.

RATIONALE :

The percentage of public water supply systems in compliance with SDWA rules is directly related to the services and enforcement activities provided by the Public Water Supply program. The program provides the systems with: monitoring, laboratory analysis, sanitary inspections, technical assistance, plan review, operator certification, training, and if necessary legal enforcement. This supports Healthy People Year 2000, Goal 11.3, to reduce the outbreaks of water borne disease from infectious agents and chemical poisoning to no more than 11 per year; and to the Minnesota Health Goals and Objectives for the year 2000, Goal 5.2, to assure that all community public water supplies and 90 percent of all noncommunity public water supply systems will provide water that does not exceed the maximum contaminant levels established by the federal SDWA requirements.

DATA SOURCE :

Measures are calculated using information from the program's information database. Input to the system is provided by field staff and laboratories. As a condition of primacy, data from the system is used to make quarterly reports to the EPA Federal Reporting Data System.

DISCUSSION OF PAST PERFORMANCE :

As new rules and stricter requirements, especially lead and copper, have been imposed by the EPA, system compliance with SDWA standards has decreased while the systems take action to remedy violations. A number of the proposed EPA rules due for promulgation over the next few years deal with contaminants that are naturally occurring in Minnesota groundwater. These rules could cause severe compliance problems for Minnesota public water supply systems. Compliance rates will again fall until systems can take remedial action and return to compliance.

PLAN TO ACHIEVE TARGETS :

The federal government has authorized a state revolving fund (SRF) to provide loans and grants to public water supplies to assist them in meeting safe drinking water standards. Minnesota has enacted legislation to set up the framework to manage the SRF funds, and the program has developed the structure to administer the SRF program. The program has obtained renewed authority to administer the operator certification program.

Goal 1 : To protect the public health in the use and consumption of water in Minnesota.
Objective 2 : To protect public and private drinking water supplies by ensuring that water wells are properly constructed

Measure 1 : Percent of inspected new wells in compliance.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Actual	96.0%	95.5%	95.7%			
Target				96.0%	96.0%	96.0%

DEFINITION :

The program inspects approximately 25 percent of all new wells constructed in the state. A "violation" means that one or more requirements of statute or rule, regardless of how small, was violated on the site of a newly-constructed well.

RATIONALE :

Compliance with construction requirements is achieved by performing the combined activities of maintaining reasonable and comprehendible regulations, licensing and training contractors, inspecting new construction, enforcing consistently against violators, and providing technical assistance to licensed contractors. If the program is successful, the number of violations should be low.

DATA SOURCE :

All violations are documented by field staff as an integral part of their surveillance activities. Violation reports are compiled by the program enforcement specialist in the central office. Violation rates are then compared to the total number of well inspections performed during the same period, and the percentage is calculated.

DISCUSSION OF PAST PERFORMANCE :

Regular field surveillance of well construction activities began during the latter part of the 1990 constructions season. At that time, it was estimated that only 85 percent of new wells met all requirements of statute and rule. As expected, significant decreases in violations occurred during the first few years of program operation. As chronic violators have been addressed and educational and surveillance programs have matured, the percentage of new wells in compliance has stabilized at approximately 96 percent. In addition, the types of violations now observed are often of a less serious nature than previously seen. The Consolidated Health Enforcement Act of 1993 has provided important additional enforcement tools which enable the program to bring violators into compliance through increased accountability and graded penalty assessment.

PLAN TO ACHIEVE TARGETS :

In 1993, the state well code (M.R. Chapter 4725) was completely rewritten to simplify, clarify, and better organize construction requirements. In addition, a 562-page Rules Handbook was created, which consolidates regulatory language, policy elaboration, graphics, and relevant excerpts from Minnesota Statutes and other referenced documents. The Rules Handbook is now widely used by both the industry and regulatory officials to ensure that wells are properly sited and constructed.

The Well Management program continues to develop and improve relationships with the regulated industries, local units of government, and other state agencies to achieve compliance. The Advisory Council on Wells and Borings continues to advise the department on contractor licensing and matters of policy.

OTHER FACTORS AFFECTING PERFORMANCE :

Field surveillance of well construction activities is seasonal and weather dependent. Demand for program activities is directly related to overall economic conditions.

Goal 1 : To protect the public health in the use and consumption of water in Minnesota.
Objective 3 : To protect groundwater by ensuring that unsealed abandoned wells are sealed.

Measure 1 : Number of abandoned wells sealed.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Actual	11,800	11,800	11,800			
Target				12,000	12,000	12,000

DEFINITION :

"Unsealed abandoned wells" are wells which are no longer in service, and threaten groundwater by serving as a channel for surface contaminants to travel deep into the ground, bypassing the natural filtration and attenuation provided when percolating water soaks through soil and rock.

RATIONALE :

The number of wells sealed is a direct measure of the success of the well sealing program. Program activities which contribute to the outcome measure include contractor licensing, operation of the well disclosure program, inspections of well sealing activities, related enforcement actions, and public education. During periods of economic slowdown, the number of property transfers and the number of consequential well disclosures will decrease.

DATA SOURCE :

Unsealed wells are primarily identified to the department through the "well disclosure" process, which requires any seller of property to disclose in writing the existence of any wells. All well sealings in Minnesota must be performed by a licensed contractor, to ensure that the job is done correctly. By law, a "Well Sealing Report" for each well sealed must be submitted to the department within 30 days. Sealing reports are entered into an automated data system, and reports are prepared from the data as needed.

DISCUSSION OF PAST PERFORMANCE :

Well sealing was stressed by the Well Management program staff for many years prior to the implementation of the Groundwater Protection Act, and consistent increases in the numbers of wells sealed occurred throughout the 1980s. Because the number of well sealings now relates directly to the number of property transactions, this measure will fluctuate directly with the economy.

PLAN TO ACHIEVE TARGETS :

The data system to track property transfer disclosures, unsealed wells, and "maintenance permits" for permitted unsealed wells is now functioning. During F.Y. 1997-98, district staff will be devoting additional time to inspection of wells claimed to be sealed. Several public informational brochures on well disclosure and well sealing are now in wide distribution.

OTHER FACTORS AFFECTING PERFORMANCE :

The number of well sealings is directly related to the number of property transactions; this measure will fluctuate directly with the economy.

Goal 1 : To protect the public health in the use and consumption of water in Minnesota.
Objective 4 : To develop wellhead protection plans for public water supply systems which use groundwater.

Measure 1 : The number of wellhead protection zone plans for the 9,541 public water supply systems.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Actual	5	25	40			
Target				450		

Goal 1 : To protect the public health in the use and consumption of water in Minnesota.
Objective 4 : To develop wellhead protection plans for public water supply systems which use groundwater.

Measure 2 : The number of wellhead protection area plans for community and nontransient systems.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Actual	12	25	36	75		
Target				75		

DEFINITION :

Compliance with the federally approved wellhead protection program and the state wellhead protection rule will include development and implementation of 1) an inner wellhead management zone for the owners of all types of public water wells and 2) a wellhead protection area plan for the owners of all community and nontransient noncommunity water supply wells. Inner zones for community wells must be completed by June 1, 1998; for nontransient noncommunity wells by June 1, 2000; and for transient noncommunity wells by June 1, 2003. The state must report on the development of these wellhead protection measures on an annual basis and meet the state defined wellhead protection program requirements which are contained in the federally approved state wellhead protection program submittal.

RATIONALE :

Protecting public water supply wells from contamination promotes public health protection by reducing the likelihood of acute or chronic diseases caused by pathogens or chemical contaminants. It is also of great economic benefit to public water supply purveyors and to taxpayers to prevent contamination of public water supply wells rather than to treat contaminated water or find alternative water supplies. Wellhead protection supports Minnesota Health Goal 5.2 to assure that all community and public water suppliers provide water that does not exceed the maximum contaminant levels established by federal Safe Drinking Water Act (SDWA) requirements.

DATA SOURCE :

Measures are currently calculated by the number of public water suppliers who voluntarily enter the wellhead protection program and the ten-year goal of phasing all public water suppliers into the program. Once the wellhead protection rule is promulgated, measures will also reflect adherence to the time schedule established for implementing inner wellhead management zones.

DISCUSSION OF PAST PERFORMANCE :

Interest by public water suppliers has steadily increased over the last three state fiscal years to the extent that the department has established a waiting list for communities who have volunteered to develop wellhead protection plans. The draft wellhead protection rule will help ensure that the protection of public wells will be extended to all water supply systems which utilize groundwater.

PLAN TO ACHIEVE TARGETS :

Reauthorization of the SDWA may provide the financial resources needed for the department to meet its goal of bringing all public water supply systems which use groundwater into the wellhead protection program within ten years. Otherwise, the community and nontransient noncommunity systems will be phased in as time and resources permit. Systems with approved plans must update their plans every ten years.

OTHER FACTORS AFFECTING PERFORMANCE :

Cooperation by other state and local agencies is essential for assisting public water suppliers with preparing and implementing wellhead protection plans. Department staff are working with these other agencies to help define the roles other agencies will play as well as to define their resource needs.

Goal 1 : To protect the public health in the use and consumption of water in Minnesota.
Objective 5 : To increase compliance with the plumbing code.

Measure 1 : Percent of inspected construction projects in compliance.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Percent of inspected construction projects in compliance.						
Actual	80%					
Target		75%	75%	80%	80%	80%

DEFINITION :

Compliance ensures that plumbing installations meet plumbing code requirements. The program inspects plumbing and water conditioning system installations. The plumbing code refers to the Minnesota Plumbing Code.

RATIONALE :

The percent of projects which comply with the code is an appropriate outcome measure because any single area of noncompliance could result in a health effect. The potential for adverse public health impact relates inversely to the percentage of projects which comply with the plumbing code.

DATA SOURCE :

All violations are documented by field staff as an integral part of their surveillance activities. Violation rates are then compared to the total number of inspections performed during the same period, and the percentage is calculated.

DISCUSSION OF PAST PERFORMANCE :

Measures taken to improve performance include: placement of plumbing inspector staff in district offices to improve efficiency; education of local inspectors on plumbing and code compliance; revision of rules for licensure of plumbers; and enhancement of enforcement efforts. The Consolidated Health Enforcement Act of 1993 has provided important additional enforcement tools which enable the program to bring violators into compliance through increased accountability and graded penalty assessment.

PLAN TO ACHIEVE TARGETS :

Continue education and enforcement efforts, and improve local enforcement. Continue to work with Plumbing Advisory Council. The plumbing program continues to develop and improve relationships with the regulated industries, local units of government, and other state agencies to achieve compliance.

OTHER FACTORS AFFECTING PERFORMANCE :

A major factor affecting the outcome statewide is inconsistent local enforcement which can result in noncomplying work. Local units of government are responsible for the inspection of about 80 percent of public-use projects in the state. Currently, the use of licensed plumbers is not required to perform plumbing work in cities of less than 5,000 population. The use of unlicensed plumbers greatly contributes to unsafe installations and lack of code compliance. In addition, program revenues from license fees will only support four inspector positions to cover the entire state. A lawsuit was filed by unlicensed general contractors and laborers against the department and detracted staff from enforcement efforts and education.

Goal 2 : To protect the public health by reducing exposure to environmental health hazards, such as asbestos, lead, radon, environmental tobacco smoke, chemical releases, and other toxic agents by assessing health risks, communicating health risk information and regulation of abatement.

Objective 1 : To reduce public exposure to asbestos through increased compliance with safe work procedures for asbestos abatement

Measure 1 : Percent of inspected asbestos-related projects in compliance.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Actual	85%	88%	78%			
Target				84%	85%	88%

DEFINITION :

Compliance with the asbestos abatement statute and rules means asbestos-related work projects and asbestos management activities meet all the requirements of the statute and rules.

RATIONALE :

Compliance with asbestos-related work and asbestos management activity requirements has a direct relationship with the success of the program in minimizing the exposure of the public to asbestos. Compliance with these requirements results from maintaining reasonable and comprehensible regulations, ensuring quality training for asbestos professionals, enforcement actions against those who violate the statute and rules, and providing technical assistance and health education to members of the regulated community and the public.

DATA SOURCE :

All violations are documented by field staff as an integral part of their surveillance activities. Violation rates are then compared to the total number of inspections performed during the same period, and the percentage is calculated.

DISCUSSION OF PAST PERFORMANCE :

The increases in compliance observed since F.Y. 1993 can be attributed to the use of the enforcement tools available under the Health Enforcement Consolidation Act of 1993. These enforcement tools enable the program to bring violators into compliance through increased accountability and graded penalty assessment. The decrease in compliance in F.Y. 1996 is due to a decreased number of random inspections as program staff concentrated on completing the rule revision process. Inspections were therefore based, in large part, on complaints received from the general public and the regulated community. Inspections based on complaints are more likely to have violations.

PLAN TO ACHIEVE TARGETS :

The program has been increasing its outreach to the public and regulated community. The program has developed approximately 38 fact sheets, and is in the process of developing several more, to ensure the regulated community and general public are aware of regulatory requirements and the health hazards of asbestos. These fact sheets include two checklists, which are similar to those used by program staff to ensure that projects inspected are in compliance with statute and rule requirements. All of these materials have been provided to all licensed asbestos contractors, permitted training course providers, and to others upon request. The program has also increased the number of presentations made to trade groups and professional associations and has increased its participation at trade shows.

The program continues to perform inspections and issue enforcement actions. The program also continues to gain experience using the enforcement tools provided by the Health Enforcement Consolidation Act.

OTHER FACTORS AFFECTING PERFORMANCE :

After a three-year rulemaking process, revised asbestos rules became effective on July 1, 1996. The outreach efforts mentioned above have been designed to educate the regulated community and the public on the requirements of these revised rules to increase compliance levels with the statute and the revised rules.

The program continues to rely on the general public and the regulated community to inform the department of asbestos projects, usually being performed by untrained and unlicensed parties, which have not followed the department's notification and permitting requirements.

Goal 2 : To protect the public health by reducing exposure to environmental health hazards, such as asbestos, lead, radon, environmental tobacco smoke, chemical releases, and other toxic agents by assessing health risks, communicating health risk information and regulation of abatement.

Objective 2 : To reduce the percentage of children with elevated blood-lead levels.

Measure 1 : Percentage of tested children 0-6 years whose blood-levels are at least 10 micrograms of lead per deciliter.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Actual		11.4%				
Target		12%	11%	10%	9%	8%

Goal 2 : To protect the public health by reducing exposure to environmental health hazards, such as asbestos, lead, radon, environmental tobacco smoke, chemical releases, and other toxic agents by assessing health risks, communicating health risk information and regulation of abatement.

Objective 2 : To reduce the percentage of children with elevated blood-lead levels.

Measure 2 : Percentage of tested children 0-6 years whose venous blood levels are at least 25 micrograms of lead per deciliter.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Actual		1.1%				
Target		2.5%	1.0%	.9%	.8%	.7%

DEFINITION :

Data provided through F.Y. 1994 reported venous blood-lead levels of 15 micrograms of lead per deciliter and 25 micrograms of lead per deciliter as measurements of the percentage of children at these levels. Currently 10 micrograms of lead per deciliter is considered an elevated blood-lead level in children by the U.S. Centers for Disease Control and Disease Prevention (CDC). The CDC recommends that an environmental assessment be required in residences of children with venous blood-lead levels of at least 20 micrograms of lead per deciliter to determine the potential sources of their lead exposures. Although the CDC recommendations are not regulatory, they are guidelines for physicians and health departments.

RATIONALE :

This report reflects the CDC recommendations and describes 10 micrograms of lead per deciliter and 20 micrograms of lead per deciliter as measurements of the percentage of children with elevated blood-lead levels. The MDH did meet both of the measured target objectives for F.Y. 1995 levels of 15 micrograms of lead per deciliter and 25 micrograms of lead per deciliter as shown by the percentage of children measured at the lower blood-lead levels of 10 micrograms of lead per deciliter and 20 micrograms of lead per deciliter.

DATA SOURCE :

Adult lead poisoning is Minnesota is largely a result of occupational exposure. Reports of elevated blood-lead levels at or above 40 micrograms of lead per deciliter in adults are referred to the Minnesota Department of Labor and Industry's Occupational Safety and Health Section. Identification and follow-up of adults is important because adults can carry lead dust home on their clothing which can contribute to elevated blood-lead levels in children.

DISCUSSION OF PAST PERFORMANCE :

The number of reports received by the MDH have been increasing. This increase is expected to continue until the number of tests stabilizes or changes occur in the guidelines for testing children for lead poisoning. In F.Y. 1995, blood-lead levels of 10 micrograms of lead per deciliter or greater were reported for 4,334 of 37,840 (11.4 percent) tested children. Blood-lead levels of 20 micrograms of lead per deciliter were reported for 408 of 37,840 (1.1 percent) tested children.

PLAN TO ACHIEVE TARGETS :

The MDH has aggressively sought federal funding to supplement state funds to improve lead surveillance, to expand health education and outreach, and to conform with federal lead-related laws. The lead program has been awarded several federal grants.

Three grants have been received from the U.S. Environmental Protection Agency (EPA) in the form of Cooperative Agreements for State Lead Accreditation which fund activities related to licensing of lead abatement contractors, workers, and lead inspectors. These are competitive grants that are awarded annually but the funds can be spent during more than one fiscal year so the grant periods overlap. The MDH received a grant of $270,376 that began in September 1994, a grant of $313,222 that began in September 1995, and will receive a grant of $263,455 beginning October 1, 1996. The MDH's share of this funding will decrease as more states adopt lead programs and compete for federal dollars.

A grant from the CDC that began July 1, 1996, is providing $406,515 to improve surveillance of blood-lead levels in high-risk populations of children. Another grant from the CDC that began in September 1995, is providing $27,000 for the Adult Blood Lead Evaluation and Survey to evaluate elevated blood-lead levels in adults.

A grant for $189,750 that was completed in May 1996, was awarded by the U.S. Department of Housing and Urban Development (HUD) to subsidize lead abatement training. The MDH has applied for another grant from HUD for about $2.8 million for lead abatement and lead hazard control. If awarded, much of this money would be passed through to the cities of St. Paul and Duluth, who are co-applicants. Awards will not be made until at least mid-October 1996. (The city of Minneapolis applied separately for a similar grant. Last year, St. Paul applied for and received a similar grant.)

OTHER FACTORS AFFECTING PERFORMANCE :

The MDH has limited staff for lead inspections. Statutory amendments effective on January 1, 1996, allowed most local health departments to transfer responsibility for conducting lead inspections to the MDH. The MDH is now responsible for inspections in 77 of Minnesota's 87 counties. The MDH's complement of lead inspectors was raised from three to five.

The cost of lead abatement or lead hazard reduction can be prohibitive for homeowners and landlords. Except for the HUD grants which target homes in which children have elevated blood-lead levels, there is no source of funding specifically for lead abatement.

The cost of liability insurance can be prohibitive to lead abatement contractors, landlords, and nonprofit, community-based organizations that try to assist families dealing with lead exposure.

Minority populations are faced with more risk factors for lead exposure and lead poisoning. As Minnesota's non-English speaking populations continue to increase, the demand for translation services for inspections and health education materials increases. Translation services are not funded.

Federal lead programs increasingly drive the state lead program, both because of legal requirements and because of available federal funding. The MDH must adopt rules that are at least as stringent as the lead accreditation regulations adopted by the EPA on August 29, 1996, within two years. The EPA and HUD have jointly issued regulations effective in September and December 1996, that require the disclosure of known lead hazards by sellers or landlords to prospective buyers or renters of residential property.

Goal 3 : To protect the public health by identifying and reducing the number of critical violations that cause foodborne illness, waterborne disease, communicable disease and to assure sanitary conditions in Minnesota.

Objective 1 : To reduce the potential for foodborne and vectorborne illness

Measure 1 : Identify and reduce the percentage of critical violations that cause foodborne illness.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Target				95%	90%	80%

Goal 3 : To protect the public health by identifying and reducing the number of critical violations that cause foodborne illness, waterborne disease, communicable disease and to assure sanitary conditions in Minnesota.

Objective 1 : To reduce the potential for foodborne and vectorborne illness

Measure 2 : Identify the compliance rate with orders issued for critical violations that cause foodborne illness.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Target				75%	80%	85%

Goal 3 : To protect the public health by identifying and reducing the number of critical violations that cause foodborne illness, waterborne disease, communicable disease and to assure sanitary conditions in Minnesota.

Objective 1 : To reduce the potential for foodborne and vectorborne illness

Measure 3 : Identify and reduce the percentage of critical violations that cause vectorborne illness.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Target				70%	65%	60%

Goal 3 : To protect the public health by identifying and reducing the number of critical violations that cause foodborne illness, waterborne disease, communicable disease and to assure sanitary conditions in Minnesota.

Objective 1 : To reduce the potential for foodborne and vectorborne illness

Measure 4 : Identify the compliance rate with orders issued for critical violations that cause vectorborne illness.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Target				75%	80%	85%

DEFINITION :

The basis for food sanitation regulation in Minnesota is the U.S. Food and Drug Administration (FDA) Food Code. The 1995 FDA Food Code is currently under review for adoption by Minnesota. The updating of the 1976 national food code was undertaken in 1991 by the FDA in response to the Healthy People Year 2000 report published by the U.S. Public Health Service (Objective 12.4, Healthy People Year 2000). The new code reflects advances in science and new technologies. Provisions of the code are compatible with the Hazard Analysis Critical Control Point (HACCP) concept. HACCP is a system for assuring food safety that involves identifying and monitoring critical points in food preparation where risks of foodborne hazards (microbial, chemical, and physical) are greatest. This same concept is applicable for regulation of lodging, recreational camping, and other licensed facilities regulated by this program for vector control.

RATIONALE :

Foodborne illness is a preventable public health problem. The identification of the violations that relate most to the potential for foodborne illness and vectorborne illnesses allows the agency to target resources to correct these violations and provides a measure of risk assessment.

DATA SOURCE :

All violations are documented by field staff as an integral part of their surveillance activities. Violation rates are then compared to the total number of inspections performed during the same period, and the percentage is calculated.

DISCUSSION OF PAST PERFORMANCE :

Past performance was measured by tracking the average food and beverage service establishment score and the percent of food and beverage establishments in compliance with sanitation standards (i.e., having a minimum score of 70 out of a possible 100).

PLAN TO ACHIEVE TARGETS :

The MDH established a Food Code Advisory Committee to review and modify the 1995 FDA Food Code for adoption in Minnesota. Anticipated adoption date is March 1, 1997 with an effective date of July 1, 1997. In addition the MDH is promulgating a Food Manager Certification Rule requiring the certification of at least one person in charge of the food service establishment. Certification will require training and passing of a national examination on safe food handling techniques, based on the 1995 FDA Food Code. The adoption of the new Food Code and the food manager certification requirement will improve the potential for a reduction in foodborne illnesses. The Consolidated Health Enforcement Act of 1993 has provided important additional enforcement tools which enable the program to bring violators into compliance through increased accountability and graded penalty assessment.

OTHER FACTORS AFFECTING PERFORMANCE :

The program recognizes the need to establish risk management objectives designed to modify behavior of those responsible for the preparation and service of food. This will require a change in program emphasis from a strict inspection focus to one that encompasses education and quality assurance monitoring. The program is developing informational material that will describe the technical information from the 1995 U.S. FDA Food Code into language that is understood by food service managers and workers. A major focus of program activity will be training program staff about the new code requirements and the preparation of materials for use by the food service industry.

Goal 4 : To protect the public health by reducing unnecessary radiation exposure to the public and users of ionizing radiation sources in Minnesota.

Objective 1 : To ensure that all facilities performing diagnostic x-rays meet all required quality control standards.

Measure 1 : Percentage of inspected facilities in compliance.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Actual Performance						
Actual	60%	63.5%	70%			
Target				75%	85%	90%

DEFINITION :

Current state law requires that all diagnostic x-ray facilities meet quality control standards described in Minnesota Rules Chapter 4730, Ionizing Radiation Rules. Compliance with quality control standards ensures that x-ray equipment and x-ray film processing will minimize unnecessary radiation exposure.

RATIONALE :

Quality control standards ensure high quality x-ray images that allow for accurate diagnosis. When a facility does not comply with the quality control standards, the facility is ordered to correct deficiencies. Failure to comply results in enforcement action.

DATA SOURCE :

All violations are documented by field staff as an integral part of their surveillance activities. Violation rates are then compared to the total number of inspections performed during the same period, and the percentage is calculated.

DISCUSSION OF PAST PERFORMANCE :

The quality control standards for x-ray equipment were upgraded when the Ionizing Radiation Rules were amended in 1991. Compliance with quality control standards has improved since F.Y. 1994 as the regulated industry has become better acquainted with rule requirements. Enforcement of quality control standards has also improved since financial penalties were introduced in December 1993. Less than 1 percent of inspections conducted during F.Y. 1994 through F.Y. 1996 resulted in administrative penalty orders with fines. Of the penalty orders issued during this period, most were for noncompliance with equipment standards and quality control standards. Annual inspections of mammography facilities for compliance with national quality assurance standards showed few deficiencies statewide.

The Disease Prevention and Control (DP&C) Division focuses on the control or elimination of communicable and chronic diseases. This division maintains statewide surveillance of communicable and chronic disease; identifies and investigates outbreaks or unusual disease problems, assures that prompt and appropriate control measures are instituted to control or eliminate the spread of disease, provides epidemiologic consultation, training and information to physicians and other health workers; conducts specific programs for control of vaccine-preventable disease, STD (including HIV/AIDS), tuberculosis (TB), Lyme disease, cancer, and other conditions. An enhanced emphasis on immunization rate assessment, access to services, coordination with private providers, and development of plans to reach targeted populations has become a model for addressing other public health problems.

Chronic Disease and Environmental Epidemiology

Cancer Surveillance - Cancer occurrence in Minnesota is monitored through the Minnesota Cancer Surveillance System (MCSS). During the seven-year period of 1988-1994, an average of 10,101 new cancers per year were diagnosed in Minnesota males and 8,955 new cancers per year were diagnosed in Minnesota females. During the same time period, an average of 4,285 cancer deaths among males and 3,932 deaths among females occurred each year. Federal monies are currently being used to enhance the quality improvement program of the MCSS, to perform death clearance activities, and to collect additional data fields.

Report on Breast Cancer Occurrence - A report is under development describing the occurrence of breast cancer among Minnesotans, using incidence data from the MCSS and mortality data from the Minnesota Center for Health Statistics to describe the numbers, rates, and trends of breast cancer among Minnesota women. The report will also include data from special one-time surveys or analyses of breast (and other) cancers in specific populations in the state.

Occupational Amputations Surveillance (Sentinel Event Notification System for Occupational Risks [SENSOR]) - SENSOR conducts indepth surveillance of Minnesota's share of the estimated 21,000 workers who suffered amputations. Amputations may greatly affect workers' job skills and reduce earning capacity. SENSOR data indicate that amputations occur at a rate that is approximately four- to five-fold greater than has been reported both nationally and within Minnesota.

Occupational Fatality Surveillance (Fatality Assessment and Control Evaluation [FACE]) - The purpose of FACE is to identify risk factors associated with fatal occupational injuries (e.g., all falls, electrocutions, work within confined spaces, work within the construction trades, and all agriculturally related deaths if they took place as a result of farm work) and to mitigate their occurrence in the future. Investigations are conducted mainly in the field through interviews of witnesses, employers, family members, etc. FACE is developing a program plan for retrofitting all older tractors with roll-over protection devices (this activity will be part of the new five-year funding cycle beginning in 1997).

Adolescent Agricultural Injury Surveillance - This three-year project funded by the National Institute of Occupational Safety and Health (NIOSH) will evaluate agricultural injuries to children.

Small Business Initiative (Wood Dust Intervention Project) - In collaboration with the University of Minnesota (Industrial Hygiene and Forest Products), the MDH responded to a National Cancer Institute (NCI) and NIOSH request for innovative epidemiologic studies on occupational exposures to possible carcinogenic substances. The four-year study focuses on wood dust (a known carcinogen) exposure in small woodworking shops which employ a large proportion of workers in this industry, and often have limited resources for protecting workers' safety and

health.

Indoor Air and Children's Health - This is a prospective cohort study, funded by the National Institutes of Health (NIH), to assess the relationships between exposure to environmental tobacco smoke, nitrogen dioxide, wood smoke, and respiratory illness in children under two years of age. Thirteen hundred (1,300) households were enrolled in the study and were followed for two years. The majority of the data analysis has been completed. Two papers have been accepted for publication and four to five more are in progress or anticipated.

Birth Defects Surveillance System - Funding from the Minnesota Legislature for FY97 has been received to start development of a Birth Defects Surveillance System (BDSS) in Minnesota. A technical advisory workgroup consisting of individuals from a variety of organizations and others interested in birth defects, has been convened to assist in planning the BDSS and preparing a legislative report.

Epidemiologic Cancer Studies - Cancer occurrence in 3M employees; cancer incidence in community cohorts; relationship between birthweight and prostate cancer; childhood neuroblastoma; cancer in Native Americans; efficacy of breast and cervical cancer screening; brain cancer and farming-related exposures; American Cancer Society Cancer Prevention Study; zinc cadmium sulfide and cancer concerns; and breast cancer mortality associated with proximity to the state's nuclear power facilities.

Acute Disease Prevention Services

Vaccine-Preventable Disease - Strategies to reach areas with low immunization rates are being implemented to improve preschool immunization levels and reach the goal of 90 percent immunization levels by the year 2000. These strategies include distributing vaccine through the Minnesota Vaccines for Children (MnVFC) program, conducting population-based parental barrier surveys, supporting immunization clinic assessment and improvement activity, helping improve provider-based and community-based registries, grants to CHS agencies for community initiatives to address areas of need, monitoring compliance with school immunization laws, statewide information campaign and outreach to families without health care providers. The Immunization Practices Task Force and workgroups address issues related to registry development, consumer education, and provider education.

Refugee Health - The MDH is the single point notification source for the pending arrival of new primary migrating refugees into the state. Accompanying their arrival information is a report of each person's overseas medical examination. A database is maintained on each refugee and the arrival forms are sent to the local community health agency in the county where the refugees are resettled. The Southeast Asian refugee program is coming to a close in 1996 but their will be a similar number of Soviet arrivals and an increase in refugees from Bosnia and several African nations (Liberia, Sudan, Somalia). The medical problems of public health concern that are found among new arrivals are primarily focused on tuberculosis and hepatitis B. Additional health problems identified are of significance to the personal health of refugees, but do not pose a threat to the surrounding community.

Lyme Disease - Public concern about Lyme disease is being addressed through distribution of brochures, exhibits, and posters on the deer tick, signs and symptoms of Lyme disease, and the importance of seeking early and effective treatment. The educational materials are distributed in clinics, state/county parks, community centers, schools, and other public areas. Local presenters are trained by MDH to present this information to community groups, park personnel, outdoor workers, and residents of areas known to contain ticks which transmit Lyme disease. In addition, the MDH developed guidelines on diagnosis and treatment of Lyme disease and disseminated them to all clinics and community health agencies in the state. If funding continues, staff will develop a curriculum for the schools, train additional people to give presentations about tick-borne diseases, and continue to assist city,

county, regional, state and private and non-profit organizations with Lyme disease activities.

Acute Disease Epidemiology

HIV and Emerging Infectious Disease - The HIV and Emerging Infectious Disease Unit maintains active statewide laboratory, hospital, and clinic-based surveillance for: 1) AIDS cases and cases of HIV infection (regardless of clinical symptoms); 2) cases of invasive bacterial infectious diseases including those caused by Haemophilus influenzae, Neisseria meningitidis, Streptococcus pneumoniae, and Groups A and B Streptococcus; and 3) unexplained deaths or serious illnesses possibly due to infectious causes among persons 1-49 years of age. These data form the basis of monitoring trends in the AIDS/HIV epidemic and the occurrence of invasive bacterial diseases in Minnesota. The sudden death and serious illness project is being conducted in an attempt to quickly learn of new and, in some instances, yet previously undiscovered causes of serious infectious disease illness.

This unit also conducts special epidemiologic studies in conjunction with the Public Health Laboratories. Such studies allow us to perform molecular characterization of selected invasive bacterial disease isolates so that we can better track the occurrence of these diseases in the community. It also maintains a program to evaluate HIV-infected health care workers to ensure that they do not pose a risk to the patients. This is a statewide program that includes all licensed health care providers. Finally, this unit provides technical expertise on the above subject areas to other sections and divisions of the MDH, to local health departments and to service providers.

Foodborne, Vectorborne and Zoonotic Disease - This unit collects data regarding cases and outbreaks of all infectious diseases transmitted through food, by ticks or mosquitoes, or animal hosts. It also is responsible for the investigation of food- and waterborne disease outbreaks with specific expertise utilized to identify and stop the outbreaks as soon as possible. This unit also works closely with the Public Health Laboratories to provide for the molecular characterization of the agents responsible for these diseases.

Vaccine-Preventable Diseases and Tuberculosis Control - This unit maintains surveillance for cases of active tuberculosis (TB) and monitors TB infection rates in various populations. The unit also provides the epidemiologic expertise to monitor the occurrence of vaccine-preventable diseases in Minnesota residents. In addition, this unit is responsible for evaluating the completeness of immunization coverage among Minnesota children. Finally, the unit provides technical expertise on tuberculosis and vaccine-preventable diseases to other sections and divisions of the MDH, to local health departments and to service providers.

Data Management and Statistical Support - The Acute Disease Epidemiology Section collects data regarding cases and outbreaks of all communicable diseases, including vaccine-preventable disease. It is essential that reports of infectious diseases be followed up to identify outbreaks and initiate control measures in a timely manner. As for a variety of diseases, monitoring incidence and trends in diseases is essential in evaluating programmatic efforts in assessing the health status of the population.

Epidemiology Field Services

Epidemiology Field Services is responsible for carrying out policies and procedures related to the control of infectious diseases of the Division of Disease Prevention and Control (DP&C) in greater Minnesota. The section was established to provide infectious disease epidemiology services at the local level throughout Minnesota. District epidemiologists are located in the MDH district offices in Rochester, Mankato, St. Cloud, Fergus Falls, and Bemidji (see attached map). This service includes disease and outbreak investigations related to reportable diseases as defined in Minnesota Rule 4605. EFS is also responsible for carrying out, and/or coordinating program

activities of the DP&C Sections of Acute Disease Epidemiology, Acute Disease Prevention Services, and AIDS/STD Prevention Services in greater Minnesota. In order to accomplish this, each district epidemiologist maintains a network of relationships with local public and private health care providers, government agencies, and other health related organizations.

The district epidemiologists provide ongoing consultation to health care professionals throughout Minnesota on the control of communicable diseases. This is done on an individual basis or by conducting regional workshops and training sessions. As part of this process, EFS has developed and manages agreements with local public health agencies (Community Health Boards [CHBs]) for the investigation and control of communicable diseases. The purpose of these agreements is to define state and local responsibilities for the control of communicable diseases. Each agreement contains a basic element that delineates responsibilities to assist the state in investigating reportable diseases, and helping in outbreak situations when a public health emergency or public health hazard is identified in the community. In addition, each CHB is asked to coordinate with its local medical community the reporting of communicable disease using a uniform statewide reporting system. The agreement also allows each CHB the opportunity to assume additional responsibilities for individual disease and outbreak investigations. This will depend on the morbidity of the disease in the community and an identified need for local involvement in the investigative process. These agreements provide for a rapid and efficient response to communicable diseases problems occurring in Minnesota.

Fundamental to any epidemiology program is the ability to conduct surveillance of the occurrence of diseases. This is done by requiring the reporting of important diseases or health conditions in health professionals. One of the major benefits of the agreement include a standardized mechanism for the reporting of communicable diseases. Prior to the agreements, there were multiple public health agencies besides the MDH that had individual reporting mechanisms. This resulted in unneeded confusion among health professionals regarding how and to whom diseases were to be reported. In addition, the DP&C agreements have standardized protocols and procedures for conducting disease and outbreak investigations. This includes delineating responsibilities for who and how investigations are to be conducted.

Since it is the responsibility of public health to conduct surveillance of disease and to conduct disease and outbreak investigations, the agreements have streamlined the ability of public health agencies to quickly respond to disease issues of public health significance. Each health board has designated, within the agreement, individuals responsible for conducting DP&C activities and has developed a procedure to inform community leaders who need to assist in the response to a public health hazard. This provides an effective statewide mechanism for the control of communicable diseases in Minnesota.

Two primary objectives of EFS for the next year include: 1) the development of MDH district plans to improve immunization levels in preschool-aged children; and 2) the development of tuberculosis (TB) programs in each CHB to conduct TB case and contact investigations, to conduct case management activities of TB cases including directly observed therapy and to conduct jail screening for TB. The outcome measures expected from these objectives are: 1) the end of the fiscal year 1995 each CHB will have incorporated at least one strategy using MDH-provided assessment data on preschool children's immunization levels; and 2) each CHB in greater Minnesota, in collaboration with the district epidemiologists, will have a TB program in place containing the elements listed in the objective.

AIDS/STD Prevention Services

Community Planning - The goal of community planning is to share with the community the responsibility for

identifying and developing effective, culturally specific prevention education interventions and services for persons with HIV/AIDS. The community planning process includes the development of a detailed and accurate description of the scope of the epidemic within different populations, a clear description of the cultural and social characteristics and the ways in which these characteristics determine the nature of the epidemic within each population; and a listing of unmet needs and of appropriate interventions and services to meet those needs. The AIDS/STD Prevention Services Section currently facilitates three community planning groups which each meet on a monthly basis (prevention, services, housing).

Community-Based Prevention Grants Program - The AIDS/STD Prevention Services Section provides programmatic funding and technical assistance to community-based and governmental organizations which have demonstrated an ability to reach adults and youth whose sexual and needle-use behavior place them at risk of infection. These programs include efforts to reach adults and youth at-risk of HIV and STD infections, including adults and youth of color. Programs utilize specialized outreach and intervention strategies including street and bar outreach, risk assessment, risk reduction counseling, and appropriate referrals for additional services. The MDH is currently supporting over 40 community-based HIV/STD prevention programs.

Mass Media Outreach - Indoor/outdoor print and electronic mass media channels are used by the AID/STD Section as a supplemental HIV/STD prevention strategy and public relations tool. Large targeted mass media campaigns are implemented once or twice each year. In addition, ongoing specialized campaigns are implemented to reach men who have sex with men, persons of color, and female sexual partners of men who have sex with men and/or injecting drug users. Technical assistance is offered to MDH-funded counseling and testing sites, community-based prevention agencies, and city/county public health departments so they can provide their own mass media campaigns.

Statewide Information and Referral - The Minnesota AIDSLine, funded by the AIDS/STD Section and operated by the Minnesota AIDS Project, is a statewide information and referral source for accurate, up-to-date information. AIDS/STD staff also provide technical support and training to all city/county health departments regarding HIV/STD prevention and services issues. The Section also maintains a statewide materials and resource distribution system providing a variety of HIV/STD prevention videos, brochures, articles, guidelines, and references, upon request. In addition, the Section provides quarterly newsletters regarding the activities of the Section-funded HIV/STD prevention and service-related programs.

HIV Services - Funds and technical assistance/guidelines are provided to community-based programs to support basic health and support services including: HIV drug reimbursement, HIV insurance continuation, case management services, dental care, emergency financial assistance, transportation services, early intervention services, and housing. Support services that enhance quality of life are also provided including: mental health services, maintenance home care, and complementary health care services. In addition, services that meet special needs are supported. These include: hemophilia support services, rural initiatives, and women's services (families specialist and day care vouchers).

Disease Intervention - Disease intervention activities are designed to interrupt and prevent transmission of HIV and other STDs through the application of casefinding activities, risk reduction/disease prevention counseling, surveillance interviewing, and contact notification activities. Staff also provide support and assistance to local health departments, physicians, and other health professionals in their effort to control these diseases.

Disease intervention serves to: 1) assist people infected with HIV and other STDs to understand the nature of the disease and how to prevent transmission to others; 2) inform unsuspecting partners of their exposure to HIV/STD,

reducing the chance that if infected, they will transmit the disease to others; 3) prevent the potentially serious complications of STDs by encouraging partners to seek STD testing and treatment; and 4) refer persons exposed to HIV for testing and treatment which may slow the deterioration of the immune system.

The Disease Intervention Unit interviewed over 1,300 persons known to have HIV, syphilis, gonorrhea, or chlamydia during 1995. Following interviews with infected patients, at least 800 partners were motivated to come to the clinic for examination and treatment of infections.

STD Surveillance - The following STDs are reportable: syphilis, gonorrhea, chlamydia infections, chancroid, HIV, and AIDS. Surveillance for these diseases is necessary to monitor trends, identify high risk populations, and evaluate the effectiveness of prevention programs.

Chlamydia/Gonorrhea Screening Programs - A large gonorrhea screening program (60,000 tests per year) has been active in Minnesota since the early 1970s. Chlamydia screening was initiated several years ago on a limited scale (6,000 tests per year) at six clinics. We are currently implementing a new chlamydia screening project with CDC Infertility Prevention funding.

HIV Counseling and Testing Program - The HIV counseling, testing, and referral program provides consultation, training, and funding to private, public health, and medical providers who offer confidential counseling and testing to their clients. Two groups of providers currently provide testing which is supported by the MDH: 8 STD/HIV clinics where both counseling and laboratory services are supported, and 15 family planning/community clinics where only laboratory services are supported. Consultation and training of counseling and testing staff is available to all testing sites and any health care provider requesting them. We currently test approximately 18,000 persons each year at these sites.

Cancer Control Section

The Cancer Control Section is responsible for the development and implementation of programs concerning early detection of cancer; the identification of, and intervention upon, risk factors associated with controllable cancers; and the identification and amelioration of barriers to access of early detection services and programs.

Education and Coalition Unit provides: 1) grants and technical assistance to 35 community-based and governmental organizations for patient recruitment activities for cancer screening, partnership coordination, and coalition building in the local catchment areas; 2) media and print materials for increasing awareness of cancer screening guidelines, training programs, and targeted community recruitment strategies; 3) collaboration with community agencies for recruitment and public awareness campaigns, an 800-phone line referral source for free or low cost breast and cervical cancer screening services, and fundraising to pay for diagnostic follow-up services for women with abnormal breast exams; and 4) the maintenance and development of a statewide coalition and a number of workgroups.

Service Delivery Unit provides: 1) technical assistance to over 200 public and private entities including CHS agencies, private medical clinics, hospitals, community clinics, tribal health councils and organizations, Title X clinics, HRSA clinics, and mammography facilities to assist with implementation of the Minnesota Breast and Cervical Cancer Program (MBCCCP); 2) payment of over 14,000 annual clinic visits, over 8,000 mammograms, and 11,000 Pap tests for women who meet age and income eligibility criteria; 3) tracking of women at clinics with MBCCCP-funded abnormal screening tests to ensure appropriate follow-up and treatment procedures; and 4) professional education of Minnesota health professionals to increase awareness and practice of state-of-the-art

cancer control methods.

Research and Evaluation Unit conducts behavioral research studies to advance the field of cancer control and to better understand issues in this field, write grants to secure funding for section work, and evaluate selected components of the CDC-funded program (MBCCCP).

Data Management Unit maintains a computerized database to monitor and report services provided through the CDC-funded MBCCCP screening program. Since January 1992, over 43,000 Minnesota women received program-funded services. It also manages data collected for the Research and Evaluation Unit studies.

BACKGROUND INFORMATION :

MEASURE TYPES: ACTIVITIES (A), EFFICIENCY (E), OUTPUT (O), OUTCOMES (OC), OTHER DATA (OD), UNIT COSTS (UC), WORKLOAD (W)

DATA BASED ON: CALENDAR YEAR (CY), FISCAL YEAR (FY), FEDERAL FISCAL YEAR (FFY), BIENNIUM YEARS (BY)

Type	Based	Measure	1994-95	1995-96
A	FY	Number of cancers abstracted	43,362	41,306e
A	FY	Number of cancers registered	22,689	22,548e
UC	FY	Cost per cancer case entered	$28.65	$29.56e
A	FY	Number of OSHA consultations regarding workplace safety	60	70e
A	FY	Number of fatal occupational accidents investigated	40	45e
A	FY	Number of sentinel occupational injuries reported	300	350e
A	FY	Number of doses of vaccine distributed by MnVAC	320,349	488,229e
OD	FY	Number of refugee arrivals	2,566	2,800e
W	FY	Number of birth packets distributed	60,612	63,398e
W	FY	Number of immunization calls from public and providers	18,247	20,000e
A	FY	Number of clinics enrolled in MnVFC program	295	312
A	FY	Number of VPD satellite training session participants	285	3,615
A	FY	Amount awarded to local community health agencies	$2,531,291	$2,106,359e
A	FY	Number of immunization materials distributed by request	1,497	2,841e
A	FY	Number of issues of immunization newsletters published	2	3e
A	FY	Number of people trained regarding Lyme disease	NA	95e
A	FY	Number of community presentations regarding Lyme disease	NA	95e
A	FY	Infectious disease outbreaks investigated	150	170e
A	FY	Communicable disease case reports recieved and summarized	6,958	6,126e

A	FY	Communicable disease publications or abstracts	12	14e
W	FY	Issues of the Disease Control Newsletter	10	10e
A	FY	EFS disease outbreak investigations	859	850e
A	FY	EFS consultations with health care professionals	2,366	2,360e
A	FY	EFS presentations to health care professionals	144	140e
A	FY	Proportion of persons tested who return for HIV counseling	85%	85%e
W	FY	Number of HIV prevention contractors	21	40e
W	FY	Case management grantees	7	8e
W	FY	"Ryan White CARE" Act grantees	30	23e
A	FY	Number of mammography providers	185	200e
A	FY	Number of cervical cancer screening sites	185	200e
A	FY	Number of clinic visits	14,200	16,500e

PROGRAM DRIVERS :

The single greatest risk factor for development of cancer is age. The lifetime risk of developing a life-threatening cancer for children born today is about 50 percent and this proportion will increase even more over time. Identification of the true scope of specific work-related conditions is limited by the lack of complete and detailed information.

The response of clinics to enrollment in MnVFC has been positive. Currently over 600 clinics are enrolled out of approximately 850 eligible clinics. The MnVFC program continues to provide significant technical consultation to providers regarding vaccine ordering and management.

Immunization funding for Minnesota comes mainly (95%) from federal grants. This funding is decreasing. This funding supports community grants for immunization and these are now at risk of substantial reductions. New initiatives such as community immunization registries are critical to meeting the year 2000 goals and protecting the public. New funding and partnerships with providers, clinics, and health plans are essential to start-up these community-based systems.

The Office of Refugee Resettlement (ORR) administers funding to assist states in refugee health assessment activities through a combined formula/competitive grant application process. Funding for Minnesota's program is based, in part, on the fact that the state receives approximately 2.2% of the total U.S. refugee arrivals.

Lyme disease educational activities have been developed and implemented by the MDH in targeted counties and the state park system. Funds are needed to extend educational activities into the schools, purchase additional educational materials for all agencies, provide training to new presenters, evaluate the effectiveness of current educational activities, and respond to inquiries about Lyme disease.

The Centers for Disease Control and Prevention (CDC) administers federal funding to assist states in refugee screening activities through a combined formula/competitive grant application process. Funding for Minnesota's program is based, in part, on the fact that the state currently receives 2.2 percent of the total U.S. arrivals.

The Acute Disease Epidemiology Section is involved in the collection of surveillance data for all communicable diseases listed in the Minnesota Rules Governing Communicable Diseases (MN Rules 4605.7000-4605.7800). Data are reviewed to ascertain outbreaks and to monitor trends in disease occurrence.

As consultants, EFS staff need to develop trusting, helpful relationships with local public health staff, with local private providers, and other MDH staff. Differing patterns of acute disease influence the amount and type of work required in a given year in each district. Staff priorities, such as vaccine preventable disease, HIV prevention programs, Lyme disease surveillance and prevention require considerable involvement by EFS staff to educate local public and private agencies and providers as well as provide input on issues in their areas. EFS staff also serve as grant monitors as needed and assist local public health staff in program planning, implementation, and evaluation.

Factors affecting rates of STD and HIV infections include biological factors (duration of infectiousness, hormonal status, coexisting STDs); personal behavior factors (sexual behavior patterns, condom use, drug and alcohol use, health-related behaviors (early use of health care and compliance with therapy); and environmental factors (poverty, peer group influences, electronic media, access to medical services, travel, variable STD/HIV prevalence in different populations).

The activities of the Cancer Control Section are federally funded. Such funding is not always predictable and may change program activities. Reaching the target populations requires awareness of motivation factors, effect of media on knowledge levels, methods for reaching the hard-to-reach, and a message that encourages adoption of a health behavior resulting in medical care. Cooperation of private providers in this program has been excellent and is a large factor in the success of the program to date.

Goal 1 : To analyze patterns of chronic disease occurrence in order to determine effective means for controlling these diseases in Minnesota.

Objective 1 : By the year 2000, an average of 110 annual public requests for investigations of cancer concerns will be completed.

Measure 1 : Number of Requests for Cancer Cluster investigations and Cancer Data

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Cancer Cluster Requests						
Actual	91	100e				
Target	133	146	100	100		
Cancer Data Requests						
Actual	40	44e				
Target	N/A	N/A	49	30		

DEFINITION :

Cancer concerns are reports of cancer (or other disease) clustering or requests for data related to a cancer concern, from anyone in the community that involve an observation of a number of similar illnesses, and the perception that the number is excessive. An investigation of a cancer concern may range from collecting information over the phone from the caller to an extensive, scientific study.

RATIONALE :

Investigations of these reports not only answer public concerns and questions and satisfy medical curiosity, but they may also provide valuable information that helps us understand the reasons for perceived excesses and knowledge of specific disease etiology. Each investigation provides an opportunity to educate citizens, communities, and policy workers about cancer risks and to correct misimpressions about the importance of environmental exposures to these risks.

DATA SOURCE :

Phone calls and letters from citizens throughout the state and the MCSS, logged by the division.

DISCUSSION OF PAST PERFORMANCE :

Based on past experience, the number of phone calls have continued to increase slowly over the past few years. Callers have concerns about cancer in family members, co-workers, neighbors, communities, and geographic portions of the state. For most callers, information about general cancer rates, rates of the particular cancer they are concerned about, and national cancer information provides the assistance they were seeking. For the more complicated situations, in-person meetings, review of cancer surveillance information, review of current literature, and more extensive interaction between MDH staff and the caller(s). Occasionally, this more involved investigation identifies the need for an evaluation of the problem to determine if a special study around the concern is warranted.

PLAN TO ACHIEVE TARGETS :

Because of the continuing public interest and awareness of cancer, we anticipate that requests for assistance in evaluating cancer exposure will increase. We will provide varying levels of staff activity to respond to those requests as needed.

OTHER FACTORS AFFECTING PERFORMANCE :

Outcome documents produced by the Chronic Disease and Environmental Epidemiology Section on cancer and other diseases are available by contacting the section at (612) 623-5216.

Goal 2 : To prevent and control vaccine-preventable diseases.

Objective 1 : By the year 2000, create a system that ensures that infants of all geographic areas, racial and ethnic groups, and socio-economic strata receive age-appropriate immunizations against diphtheria, tetanus, pertussis, poliomyelitis, measles, mumps, rubella, Haemophilus influenzae type B, and hepatitis B, such that 90 percent are up-to-date when measured within two months of the date(s) on which they were to be vaccinated.

Measure 1 : Proportion of children who were up-to-date for immunizations.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
4 months of age						
Actual	91%	90%				
Target			91%	92%	93%	93%
6 months of age						
Actual	78%	82%				
Target			83%	84%	85%	86%
8 months of age						
Actual	69%	70%				
Target			72%	74%	76%	78%
17 months of age						
Actual	69%	69%				
Target			70%	71%	72%	73%
20 months of age						
Actual	55%	54%				
Target			56%	58%	60%	62%
24 months of age						
Actual	69%	71%				
Target			74%	76%	78%	80%

DEFINITION :

Immunization rates for fiscal years 1993, 1995, and 1996 are based on retrospective kindergarten surveys conducted by the MDH. The school immunization records of children in kindergarten are reviewed to determine, retrospectively, their immunization status from birth throughout the preschool years. During 1992-93 the entire kindergarten cohort was evaluated; in 1994-95 and 95-96 statistically valid samples were selected to estimate immunization coverage throughout the state. Rates are defined as the percentage of children up-to-date within two months of the date(s) on which they were to be vaccinated (i.e., 4,6,8,17, and 20 months of age). Estimates for future vaccine coverage levels are based on incremental improvements seen historically.

DISCUSSION OF PAST PERFORMANCE :

For the second year in a row, there were no measles cases reported during 1994. However, there were 9 cases of measles identified by MDH during 1995. These represent the first measles cases identified in the state since July 1992. All nine of the cases had an affiliation with a religious community who had not been systematically immunizing the children enrolled in their K-12 school. In 1994, 142 cases of pertussis were reported and in 1995 there were 237 reported cases.

Immunization rates are at or near all time highs for Minnesota. However they fall short of the year 2000 immunization goal. Previous studies have shown that immunization levels can vary by geographic area. All counties in the state have some areas of lower immunization rates.

PLAN TO ACHIEVE TARGETS :

The MDH continues to work with local public health agencies in identifying areas of under-immunization, conducting outreach to ensure access to preventive care for infants, developing local professional and consumer education strategies, and working with private providers and child health programs such as WIC to ensure children receive age-appropriate immunizations. MDH is also providing leadership in developing provider- and community-based (regional) immunization registries to facilitate accurate recording of immunization histories. Statewide and local assessment activities continue as a means to identify pockets of under-immunization and how immunization levels could be raised. Recruitment of private providers to delivering federally-supplied vaccines continues as a means to ensure access to age-appropriate immunizations.

OTHER FACTORS AFFECTING PERFORMANCE :

Approximately 85% of the immunizations received by MN children are provided by the private medical sector. Influencing medical and delivery practices can be accomplished through cooperative working relationships with local community health agencies. Inadequate access to medical care, incomplete understanding by parents of the need for and when to get immunizations, problems in completing the series on time, and parent motivation are among the barriers to achieving this goal. Federal resources and priorities have been inconsistent in the past several years and could be a factor in being able to reach the goal for the year 2000.

Goal 3 : To conduct surveillance for acute diseases so that outbreaks can be identified, investigated, and controlled; and so that trends in disease occurrence can be monitored for determining and assessing control strategies.

Objective 1 : Reduce the spread of communicable diseases of public health importance.

Measure 1 : By the year 2000, the incidence of tuberculosis (TB) will be 2/100,000 or less, annual cases of measles = 0, mumps <10, & pertussis <100 in underimmunized and the annual increase in AIDS cases will be 3% or less.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
TB incidence						
Actual	3.1	3.4				
Target			<3.0	<3.0	<3.0	<2.5
Measles Cases						
Actual	0	9				
Target			0	0	0	0
Mumps Cases						
Actual	5	11				
Target			<10	<10	<10	<10
Pertussis Cases						
Actual	142	237				
Target			<200	<150	<125	<100
AIDS Cases						
Actual	312	321				
Target			<325	<300	<300	<300

DEFINITION :

Cases of communicable diseases are reported according to Minnesota Rules Governing Communicable Diseases (MN Rules 4605.7000 - 4605.7800). Case definitions that are employed to define cases are those put forth by the Council for State and Territorial Epidemiologists in conjunction with the Centers for Disease Control and Prevention. Data are frequently validated by special surveillance studies or other validation methods to assure accurate case counting and identification.

RATIONALE :

Measuring the total number of cases of disease per year demonstrates the actual frequency of disease occurrence. Maintaining surveillance for communicable diseases, conducting outbreak investigations to implement control measures, and conducting special epidemiologic studies to answer pertinent public health questions about these diseases, are all core public health functions.

DATA SOURCE :

Data are collected from physicians, hospitals, laboratories, and other persons caring for patients with communicable diseases. Surveillance for HIV/AIDS is laboratory-based and also conducted through an active system of AIDS care providers.

DISCUSSION OF PAST PERFORMANCE :

Tuberculosis cases have increased gradually in Minnesota over the last five to six years due to the resurgence of TB nationally and the occurrence of cases in hard-to-access populations, particularly foreign-born persons, homeless persons, and persons with other issues such as chemical dependency. Cases in 1995 continued to show a slight increase over the previous year. Fifty percent (50%) of cases occurred among persons born outside of the United States.

In 1995, 9 cases of measles and 11 cases of mumps were reported. The measles cases resulted from an outbreak which occurred in a religious community, many of whom had not been previously vaccinated. Pertussis (also known as whooping cough) case numbers were high and reflect increased activity for this disease. Of cases 2 months of age and older, 77 (45%) of 172 with known vaccine histories were age-appropriately vaccinated, indicating the limitations of currently available vaccines.

Although there was no measles activity in 1994, the cases reported in 1995 indicate a need to maintain high vaccination coverage levels among preschool and school-age children, and greater implementation and enforcement of the two-dose schedule among high school and college students in all communities to ensure the elimination of endemic measles transmission. Mumps cases continue to be low. Pertussis, while still at historic lows, increased in number of cases reported in 1995. This is consistent with trends seen at the national level.

Cases of HIV/AIDS in Minnesota have plateaued somewhat over the last two to three years; however, this plateau level continues to remain relatively high and we anticipate that this pattern will continue through at least the next several years.

PLAN TO ACHIEVE TARGETS :

TB - Current efforts are targeted to improving TB diagnosis and treatment among the foreign-born population through outreach activities and use of directly observed therapy. Our efforts need to be targeted to rapid identification of such cases and appropriate treatment before infection spreads to others.

Vaccine-Preventable Diseases - The MDH monitors the progress of immunization action plans by assessing, on an ongoing basis, immunization levels in preschool-aged children throughout Minnesota. Efforts to improve laboratory-based surveillance for vaccine-preventable disease are being implemented.

HIV/AIDS - Technical consultation on HIV/AIDS prevention issues will continue to be provided to local health agencies, care providers, and community-based organizations. Active surveillance for AIDS/HIV infection will continue according to current methods.

OTHER FACTORS AFFECTING PERFORMANCE :

As more foreign-born persons come into the state from TB endemic areas, more cases of TB are likely to identified. TB cases are somewhat dependent on national trends since the populations affected by TB tend to be relatively mobile.

The major strategy for controlling vaccine-preventable diseases is improving vaccination levels throughout the state. While this strategy is fairly effective for measles and mumps, it is less effective for pertussis since the current vaccines are less than ideal. New vaccines such as varicella (chickenpox), Hepatitis B, Hepatitis A, have been introduced and are very effective. However the childhood schedule is now much more complex and difficult to understand for providers. Parents are expecting providers to more actively tell them what shots are needed. This is increasingly more difficult without widespread use of immunization registries. Federal funding provides 95% of current program activities. These funds are expected to decrease unless they are replaced by state funds.

Cases of AIDS are also somewhat dependent on numbers of people moving into the state with HIV infection. We do not have data specifically addressing this issue; however, persons moving into the state with HIV infection could ultimately affect AIDS cases numbers since most of these people will eventually develop AIDS over time.

Goal 4 : To conduct special epidemiologic studies of acute diseases to better define the epidemiology of such conditions and to assess control strategies or define pertinent clinical practice issues.

Objective 1 : Identify foodborne disease outbreaks and implement control measures within three working days after identifying the outbreak.

Measure 1 : Cases of foodborne/waterborne disease outbreaks identified and control measures implemented within three days after identifying the outbreak.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
No. of outbreaks						
Actual	20	23				
Target			30	<30	<30	<30

DEFINITION :

An outbreak is defined as two or more cases of a specific infection which are epidemiologically linked to a common food or water source.

RATIONALE :

By reviewing reports of foodborne and waterborne pathogens that are submitted to the MDH, outbreaks can frequently be identified. Investigations of these outbreaks are essential to identifying potentially contaminated vehicles and implementing control strategies as needed. Also, monitoring the occurrence of outbreaks can lead to long-term prevention strategies.

DATA SOURCE :

Data are collected from physicians, hospitals, laboratories, and other persons caring for patients with communicable diseases. Much of the surveillance for these conditions is laboratory-based.

DISCUSSION OF PAST PERFORMANCE :

Reports of foodborne disease have remained relatively stable over the past several years. We anticipate that the number of outbreaks identified may actually increase in the future due to more aggressive case finding and increased awareness of foodborne disease by providers. The MDH has made a concerted effort to educate care providers about the need to identify enteric pathogens so that outbreaks can be identified and investigated appropriately.

PLAN TO ACHIEVE TARGETS :

The Acute Disease Epidemiology Section is working closely with the Division of Public Health Laboratories to identify outbreaks of foodborne disease that would previously have gone unrecognized. This program includes DNA "fingerprinting" of common organisms. This fingerprinting technique allows identification of subsets of isolates that may be derived from a common source. This is a new program that the section is now implementing and should allow more timely identification of outbreaks and identification of outbreaks that may have previously gone unrecognized. These efforts may actually increase case reporting, but will ultimately lead to improved control of foodborne diseases.

OTHER FACTORS AFFECTING PERFORMANCE :

The new technology that we are now using to identify foodborne outbreaks will lead to the recognition of community-based outbreaks that are difficult to investigate where identifying the common vehicle involved can be challenging. Some of these investigations require extensive case-control studies which may require many hours of staff time. Therefore, in some instances, despite our best efforts, determining the source and implementing control measures within three working days may be somewhat difficult to achieve.

Goal 5 : To prevent death and disability from human immunodeficiency virus (HIV) and other sexually transmitted diseases (STDs) by providing statewide leadership to prevent transmission, and ensure the availability of prevention services for high-risk populations and health and supportive services for infected persons.

Objective 1 : Reduce the overall incidence of STDs and reduce the overall incidence of STDs in communities of color to meet Year 2000 Objectives.

Measure 1 : Prevalence rate for chlamydia; incidence rates for gonorrhea and syphilis (see below).

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Chlamydia						
Actual	160	132				
Target			125	125	125	125
Gonorrhea						
Actual	74	62				
Target			53	53	53	53
Prim/Sec Syphilis						
Actual	1.2	1.0				
Target			1.2	1.2	1.2	1.2
Chlamydia Females						
Actual	244	201				
Target			212	212	212	212
15-19 y/o Females						
Actual	1,681	1,380				
Target			1,230	1,230	1,230	1,230
Gonorrhea Blacks						
Actual	1,754	1,419				
Target			1,505	1,505	1.505	1,505
15-19 y/o						
Actual	375	284				
Target			242	242	242	242
Women (15-44)						
Actual	151	132				
Target			95	95	95	95
Prim/Sec Syphilis Blacks						
Actual	41	30				
Target			43	43	43	43

DEFINITION :

Physicians and laboratories are required to report cases of the above diseases to the MDH. Laboratory surveillance serves to increase the completeness of reporting. The rates are expressed as cases per 100,000 residents. The STD rates are used to describe affected populations, measure progress toward Minnesota Detailed STD surveillance data are reported annually in the "Minnesota STD Surveillance Report." Copies are available from the AIDS/STD Prevention Services Section (612/623-5698).

Chlamydia is a bacterial infection which may involve the lower or upper genital tract in women and can lead to infertility and ectopic pregnancy. In both men and women, symptoms are often mild or absent. A child infected at the time of delivery may develop an eye infection or pneumonia. Chlamydia is measured by a prevalence rate.

Gonorrhea is a bacterial infection which may involve the lower or upper genital tract in women which can lead to infertility and ectopic pregnancy. A child infected at the time of delivery may develop an eye infection or bloodborne infection. Gonorrhea is measured by an incidence rate.

Syphilis is a bacterial infection which may cause symptoms of rash, enlarged lymph nodes, flu-like symptoms, and long term complications affecting the brain, heart, and other organs. Syphilis during pregnancy may lead to miscarriage and stillbirth. Syphilis is measured by an incidence rate. The above rates refer to primary and secondary syphilis which are the first two stages of syphilis, usually 6 - 9 weeks after infection.

Incidence rates are the number of new cases occurring in a population over a specified time period (e.g. cases per 100,000 residents per year). Prevalence rates are a measure of the frequency of disease in a population at a specific point in time. It is expressed as the total number of persons who have the disease at a given time (e.g., cases per 100,000).

DISCUSSION OF PAST PERFORMANCE :

Multiple strategies are used to reach persons at risk with similar messages over time. In addition to MDH-sponsored activities, a grants program supports activities in community-based organizations who can more easily reach persons at risk.

PLAN TO ACHIEVE TARGETS :

Minnesota is implementing a new federal initiative to increase community involvement with HIV/STD prevention activities. These activities will influence future program plans and strategies which may affect disease rates.

OTHER FACTORS AFFECTING PERFORMANCE :

Diseases such as syphilis which have small numbers can vary greatly from year to year. HIV/STD prevention activities include MDH-sponsored media campaigns, disease intervention activities, and community-based organization outreach and programs. Preventing new cases of disease involves an interaction between individuals at risk, health care providers, and organizations which can inspire behavior change that reduces high risk behavior. The ultimate choice about behavior change, however, remains with the individual.

Goal 6 : To increase the proportion of age-appropriate Minnesota women who are screened for breast and cervical cancer.

Objective 1 : To increase breast cancer screening rates among uninsured and underinsured women age 40 and older who live in areas served by MN Breast & Cervical Cancer Control Program provider clinics.

Measure 1 : Number of women completing MBCCCP mamography screening.

	F.Y.1993	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998
Mammograms done						
Actual		5,620	6,495			
Target				7,487	9,000	9,000

DEFINITION :

The number of women age 40+ with completed MBCCCP enrollment forms and mammography test report forms recorded in the MBCCCP Tracking and Follow-up System. Over 200 clinic sites throughout Minnesota participate in the MBCCP. The MBCCCP pays for office visits and mammogram test costs for any woman age 40 and older who is uninsured or underinsured and who has an income at or below 250 percent of the federal poverty level.

RATIONALE :

At this time, there is no clear method to measure the overall impact of the MBCCCP including its efforts to increase age-appropriate breast cancer screening for all Minnesota women. Additionally, there is no adequate method to determine breast cancer screening rates in Minnesota. National objectives are that by the year 2000, 80 percent of all women will report that they have received a clinical breast exam or mammogram.

DATA SOURCE :

MBCCCP's Tracking and Follow-up System.

DISCUSSION OF PAST PERFORMANCE :

Mammography rates increased greatly from 1992 to 1993 and increasd slightly for 1994. Significant increases are expected into the next two years as the program focuses on mammography utilization, and the number of sites and promotional activities increase. The program has been very successful in reaching women for whom health care access has been traditionally lower, most notably those from the communities of color. Over 20 percent of women screened are non-white and over 10 percent are Native American.

PLAN TO ACHIEVE TARGETS :

Targets will be met by focusing staff resources on strategies to increase recruitment to program-funded screening, continuing technical assistance to our existing network of providers, as well as by expanding our provider network. A grants program to CHS agencies and selected community organizations will be continued through which they will publicize and perform other forms of outreach to women in the community. The size of the provider network will be expanded through a request for application.

OTHER FACTORS AFFECTING PERFORMANCE :

Breast and cervical cancer screening is affected by a variety of factors not directly within the MDH's control including: policies of medical care provider and payers; lack of accredited mammography services and cervical screening clinics in rural areas; provider insensitivity to cultural barriers regarding breast and cervical cancer screening; and outreach activities of voluntary organizations such as the American Cancer Society.

Goal 6 : To increase the proportion of age-appropriate Minnesota women who are screened for breast and cervical cancer.

Objective 2 : To increase cervical cancer screening rates among uninsured and underinsured women age 25 and older who live in areas served by MN Breast & Cervical Cancer Control Program provider clinics.

Measure 1 : Number of women completing MBCCCP cervical cancer screening.

	F.Y.1994	F.Y.1995	F.Y.1996	F.Y.1997	F.Y.1998	F.Y.1999
Pap smears done						
Actual	12,538	11,022				
Target			12,136	14,000	14,000	14,000

DEFINITION :

The number of women age 25+ with completed MBCCCP enrollment forms and Pap test report forms recorded in the MBCCCP Tracking and Follow-up System. The MBCCCP pays for office visits and Pap test costs for women age 25 and older who are uninsured or underinsured, and who have incomes at or below 250 percent of the federal poverty level.

RATIONALE :

Through the MBCCCP Tracking and Follow-up System, we maintain information on the number of women screened through the subsidized program administered by the MDH. At this time, there is no clear method to measure the overall impact of the MBCCCP including its efforts to increase age-appropriate cervical cancer screening for all Minnesota women. Additionally, there are no adequate means to determine cervical cancer screening rates in Minnesota. Minnesota has already met the national objective, which is that by the year 2000, 95 percent of all women will report that they have received a Pap test.

DATA SOURCE :

MBCCCP's Tracking and Follow-up System.

DISCUSSION OF PAST PERFORMANCE :

The number of Pap tests provided increased substantially from 1992 to 1993, and then declined in 1994. The decline occurred because eligibility for services was changed from age 18 to 25, decreasing the provider sites which routinely saw large numbers of eligible women. (As the number of screening sites and promotional and outreach efforts increase in late 1994 and beyond, these numbers are expected to rebound.)

PLAN TO ACHIEVE TARGETS :

Targets will be met by focusing staff resources on strategies to increase recruitment to program-funded screening, continuing technical assistance to our existing network of providers, as well as by expanding our provider network. A grants program to CHS agencies and selected community organizations will be continued through which they will publicize and perform other forms of outreach to women in the community. The size of the provider network will be expanded through a request for application.

OTHER FACTORS AFFECTING PERFORMANCE :

Breast and cervical cancer screening is affected by a variety of factors not directly within the MDH's control including: policies of medical care provider and payers; lack of accredited mammography services and cervical screening clinics in rural areas; provider insensitivity to cultural barriers regarding breast and cervical cancer screening; and outreach activities of voluntary organizations such as the American Cancer Society.

APPENDIX

HEALTH POLICY AND SYSTEM COMPLIANCE

The Department of Health reorganized in July 1995. The Health Care Delivery Policy (HCDP) and Occupational and Systems Compliance Divisions (OSC) merged and the Office of Rural Health and Primary Care moved from the HCDP Division to the Community Health Services Division. The Commissioner of Heath's functions and responsibilities for emergency medical services transferred to the Emergency Medical Services Regulatory Board effective July 1, 1996. These responsibilities were in the OSC Division.

Changes in Objectives/Measures from the 1994 Report:

Objectives and measures that do not appear in the 1996 report (references are to the 1994 report).
P. 38
Objective 2: To promote cost savings and improve quality of care and access through administration of the antitrust exception process.
Measure (1): To provide written analysis and prepare recommendations for each antitrust exception application submitted.

The level of interest in the health care community for this activity never developed as anticipated, so the measure was dropped from the 1996 report.

P.39
Objective 3: To promote the adoption of practice parameters by medical care practitioners which impact on the cost and effectiveness of health care.
Measure (1): The number of practice parameters evaluated (number approved for dissemination).

Legislative authority for this activity was repealed in the 1995 MinnesotaCare legislation.

P. 40
Objective 4: To collect quality-of-care and access data from health plans to enable consumers and purchasers to make informed decisions.
Measure (1): The number of quality-of-care and access indicators collected (number of health plans represented).

The responsibility for this activity was transferred to the Minnesota Health Data Institute in the 1995 MinnesotaCare legislation.

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